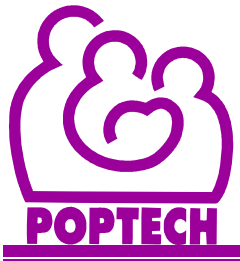

USAID BIRTHSPACING PROGRAMMATIC REVIEW

AN ASSESSMENT OF COUNTRY–LEVEL PROGRAMS, COMMUNICATIONS, AND TRAINING MATERIALS

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ACRONYMS

ADAR	Asociación para el Desarrollo Amazónico Rural (Association for Rural Amazonian Development) (Peru)
ADRA	Adventist Development and Relief Agency International
APROPO	Apoyo a Programas de Población (Advocacy in Population Programs) (Peru)
BCC	Behavior change communication
CA	Cooperating agency
CEDPA	Centre for Development and Population Activities
CIES	Centro de Investigación, Educación y Servicios (Center for Investigation, Education and Services) (Bolivia)
DHS	Demographic and Health Survey
FESAL 98	El Salvador National Family Health Survey 1998
FHI	Family Health International
FP	Family planning
GH/PRH	Bureau for Global Health, Office of Population and Reproductive Health (USAID)
HCP	Health Communication Partnership
IEC	Information, education, and communication
INFO	Information and Knowledge for Optimal Health Project
INPPARES	Instituto Peruano de Paternidad Responsable (Peruvian Institute for Responsible Parenthood) (Peru)
IPPF	International Planned Parenthood Federation
JHU/CCP	Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs
MINSA	Ministerio de Salud (Peru)
MWRA	Married women of reproductive age
NGO	Nongovernmental organization
PROCOSI	Programa de Coordinación en Salud Integral (Collaborative Program for Integrated Health) (Bolivia)
PROSIN	Proyecto de Salud Integral (Integrated Health Project) (Bolivia)
PVO	Private voluntary organization
RCP	Radio Communication Project (Nepal)
SIFSA	State Innovations in Family Planning Agency (India)
STARH	Sustaining Technical Achievement in Reproductive Health (Indonesia)
SUMI	Ley del Seguro Universal Materno Infantil (Law for Universal Maternal and Infant Safety) (Bolivia)
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UPHOLD	Uganda Program for Human and Holistic Development
USAID	United States Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

THE ISSUE

Recently, the topic of birthspacing and the role of timing births or pregnancies in maternal and child health have received increased attention because of new research that links longer birth intervals with substantial reductions in mortality and morbidity. For example, a 2000 study using Demographic and Health Survey (DHS) data from 18 countries and assessing the outcomes of more than 430,000 pregnancies found that children born 3 years or more after a previous birth are healthier at birth and more likely to survive at all stages of infancy and childhood through age 5 (Rutstein 2002). The difference in the risk of death was significant in 17 of the 18 countries analyzed and the increased risk of death was substantial.

When compared with children born less than two years after a previous birth, children born after a three to four–year interval were found to be

- 1.5 times more likely to survive the first week of life,
- 2.2 times more likely to survive their first 28 days,
- 2.3 times more likely to survive the first year, and
- 2.4 times more likely to survive to age 5.

The same study concluded that two-year birth intervals are associated with higher child mortality risks than births occurring at 36–month intervals and represent

- a 26 percent increased risk of death for newborns,
- a 43 percent increased risk of death in infants, and
- a 51 percent increased risk of death among children under 5.

Analyses of developing countries show that demand for birthspacing is substantial, particularly among younger, lower parity women, and that much of this demand remains unsatisfied. For example, the portion of the total demand (all married women of reproductive age [MWRA]) for family planning due to an interest in spacing ranged from about 33 to 75 percent of total demand in 14 of 15 countries examined. Similarly, the portion of total unmet need among all MWRA for family planning due to spacing is also substantial, ranging from about 25 to 66 percent of total unmet need.

Among younger age cohorts, spacing is by far the main reason for any demand for family planning. For example, among married women who are 29 years or younger, the portion of the total demand for family planning for spacing reasons varied from about 66 percent to over 90 percent in 12 of 15 countries examined. In the other three countries, the demand for birthspacing represented at least 50 percent of the total demand for family planning among women who were less than 30 years old. A similar pattern emerged for married women 29 or younger for the unmet need for family planning due to birthspacing: the birthspacing portion of the total unmet need ranged from about 50 percent to over 90 percent of the total unmet need in the 15 countries.

In 2001, the United States Agency for International Development (USAID)'s cooperating agencies (CAs) began a discussion around the topic of birthspacing and began reviewing the implications of new research. Among the issues raised was the extent to which information about the health effects of birth intervals is conveyed to clients through service delivery programs in the developing world. Questions arose as well over how much of the recent research on the health impact of birth intervals is reflected in programs internationally.

TASK AND METHODS

The scope of work for this birthspacing programmatic review indicated that two broad questions should be addressed:

- How effectively are programs educating families, providers, and policymakers about birthspacing as a maternal and child health intervention?

- What program improvements are needed?

The purpose of the review included determining how well service delivery programs are or have been informing families about the health effects of birth intervals, and to describe the place of birthspacing within current service delivery efforts.

In response, the assessment team developed a multifaceted methodology for the collection of information for the assessment of birthspacing in programs. Information gathering included three general efforts focusing upon activities in-country, communications materials generally available, and examples of training materials submitted by CAs. For country-level data collection, USAID asked the PRIME, CATALYST, and Advance Africa projects as well as EngenderHealth to assist in gathering information within countries. CA staff used the standard questionnaire instrument and assessment guidelines to gather information from informants in-country and to report their findings.

Information (gathered by CA staff) from 17 countries in Africa, Asia, and Latin American was used in the assessment of birthspacing at the country level. The 17 countries in the assessment were Bangladesh, Bolivia, Egypt, El Salvador, Ethiopia, Guatemala, India, Jordan, Kenya, Nepal, Nigeria, Pakistan, Paraguay, Peru, Rwanda, Uganda, and Yemen. Additionally, members of the assessment team conducted information-gathering visits to 5 (Bolivia, India, Nigeria, Peru, and Uganda) of the 17 countries.

MAIN FINDINGS

Policy, Norms, and Standards

At the sectoral level, 13 of the 17 (76 percent) of the countries examined have policies and policy documents that acknowledge a role for birthspacing in family planning service delivery. National-level policies in 4 of the 17 countries do not mention birthspacing significantly. Typically, policies that mention birthspacing link it to improvements in the general health of mothers and children. **Most policies or standards, however, do not**

relate birth intervals to any specific health risks and there usually is no clear linkage between birthspacing or birth intervals and mortality. Birthspacing is usually dissociated from mortality-reduction objectives in health policies, service standards, program management norms, and practice guidelines.

When a birth interval is mentioned, policies and standards most often include a two-year time period in accordance with national understanding of World Health Organization (WHO) guidelines. For example, public sector policies in 7 of the 17 countries identify a two-year interval, 3 countries identify a two to three–year interval, and 7 countries do not specify an interval. In practice, however, most of the countries exhibit internal inconsistencies with regard to recommended birth intervals, usually ranging from two to three years.

Communications and Birthspacing

More than half (9 of 17) of the countries have some communications efforts that include birthspacing topics. **The content of the communications, however, often does not relate birthspacing with any specific health risk**. In Nepal, Bolivia, and Peru, for example, birthspacing messages promote the economic benefits of spacing. Although there are some exceptions (Bangladesh and Jordan), zero parity women generally are not included in efforts to educate women about postponing a first birth. In seven countries, there was no use of mass media on family planning communications at all (for spacing or limiting).

A search of the communications materials database at the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (JHU/CCP) indicated that of the 4,353 examples of family planning communications materials assembled from countries worldwide, only about 6 percent were coded as having any birthspacing content. When birthspacing was included in the assembled communications materials, it was rarely associated with specific health risks. For, example, 5 percent or less of the examples of birthspacing in communications materials were linked to maternal mortality, infant mortality, high-risk pregnancies, or adolescent pregnancy.

This pattern suggests that birthspacing has received weak treatment in communications efforts in the past. Some of the current, stronger examples of birthspacing communications were developed recently and often are being implemented on a pilot basis in a limited area of a country.

Training and Birthspacing

An independent review of training materials revealed a similar situation with regard to birthspacing. The review found the following gaps or missed opportunities in training materials for conveying the relationship between birthspacing and reducing health risks:

- half of the documents discussed the potential needs of young, low parity women;

- 10 percent of the documents recommended counseling techniques that can be effective for contraceptive choices for zero parity women; and

- 20 percent of the documents included the concept that some zero parity women are interested in postponing their first birth.

Birthspacing messages in these documents, for the most part, addressed the needs of adolescents, teenagers, young people, women under 18, postpartum women, and postabortion women. The birthspacing needs of postadolescent (19 or older), zero parity women were almost always overlooked.

Barriers to Birthspacing

Respondents to the questionnaires applied in the countries identified barriers that some women face when trying to exercise their birthspacing desires. Although responses varied, some barriers were common across many countries, including cultural traditions and norms; gender inequality, including intimate partner violence; lack of knowledge of contraceptive methods or source; myths, fears, and health concerns about contraceptives; lack of contraceptives; method failure; poor quality of services (including provider bias and poor counseling); problems accessing services; and poverty. Fourteen of the 17 country reports submitted by CAs cited the lack of contraceptives as a barrier to birthspacing (Egypt, Jordan, and Nigeria were the exceptions).

CONCLUSIONS

Based on all the information gathered and the independent assessments of programs, training materials, and communications efforts, it is clear that birthspacing interventions are often a weak part of family planning programs. Assumptions are common that birthspacing efforts are an integral and active element of family planning programs; however, the findings of this assessment suggest that this is not necessarily the case. **The specific health benefits of longer birth intervals are usually not a program emphasis within family planning service delivery organizations**. Furthermore, the fact that birthspacing services are not typically a part of health interventions being pursued in countries by those offices charged with reducing maternal or child mortality illustrates that **there are significant programmatic gaps between contraceptive service delivery and the contribution longer birth intervals could make to improvements in maternal and child health**. As long as these gaps exist, the potential contribution of longer birth intervals to mortality and morbidity reduction is unlikely to be fully realized.

KEY RECOMMENDATIONS

National polices should acknowledge the significant role of birthspacing in mortality reduction strategies. If the potential contribution that birthspacing can make to mortality reduction is to be realized, policies need to clearly recognize the importance of longer birth intervals to mortality reduction. Future policy discussion efforts should include an effort to have birthspacing services identified as a legitimate intervention for reducing both maternal and child mortality.

Policies and service delivery guidelines should focus birthspacing efforts on young, low parity women. Policies should also clearly acknowledge the segments of the population (young, low parity women) that can most benefit from birthspacing. Zero

parity women, particularly, need to be identified in policies and service delivery guidelines as having some preexisting demand for birthspacing and as being eligible for quality services that require the attention of service providers and program managers.

Training needs to better prepare health care workers to provide birthspacing services that respond to the needs of young, low parity women, particularly in counseling. Donors (such as USAID, the United Nations Population Fund [UNFPA], WHO, and the United Nations Children's Fund [UNICEF]) should develop standard protocols for training providers to respond to the needs of young, low parity women, including the recently married, zero parity woman. Additionally, USAID could include a specific birthspacing training component in its relevant global projects to develop model training protocols for birthspacing. Such training protocols should be oriented to service providers, supervisors of service providers, and service delivery program managers.

Communications should educate about the specific health risks associated with the timing of pregnancies. Greater effort is needed in future communications efforts to incorporate messages about the specific health risks that can be minimized through longer birth intervals. Additional counseling and client–provider interaction tools are needed for use with young, low parity women. Additional information materials on birthspacing for the zero parity, recently married woman are needed. Given the relative weakness of birthspacing in communications efforts in some countries historically, greater emphasis should be given to birthspacing messages, with clearer health content, within globally and bilaterally funded communications programs for reproductive health.

Communications are needed to address the barriers women face in exercising choice for the timing of pregnancies. Behavior change communication activities should be increased that address the barriers women face (such as lack of knowledge, fear of side effects, and provider bias) in implementing their birthspacing desires. Similarly, communication and program efforts need to develop culturally appropriate strategies for reaching men and other family members (such as mothers-in-law) about how healthy birth intervals can reduce health risks.

Specific needs of at-risk women should be addressed in service delivery programs. In countries where intimate partner violence is a substantial issue, greater emphasis is needed to ensure that women have contraceptive options that are not partner compliant–dependent. Reaching males with information about the health benefits of birthspacing is also of primary importance. With gender inequalities frequently mentioned as an issue affecting the ability of women to time pregnancies when they choose, efforts are needed to involve males in achieving improved health outcomes for women and children through birthspacing.

A commonly used sector-level indicator across countries for the status of birthspacing is needed. If birthspacing is to be taken more seriously than it currently is, it needs to be reflected in the standards of program success that donors and program managers regularly use. Therefore, age-specific birth intervals should be incorporated as a standard program indicator or for measuring progress against Strategic Objectives in both population and maternal and child health sectors. Age-specific interval information will provide important perspectives for programs to better understand which portions of the client population have the greatest need for birthspacing services. This indicator also

would allow programs to orient outreach services more precisely than is currently possible.

The right to know about the health risks associated with the timing of pregnancies should be a guiding principle for all service delivery programs. Donors and development agencies should advocate for the principle within service delivery programs of women's right to know of the correlation between birth intervals and health risks for women and children. To incorporate this principle meaningfully in many programs will require considerable support and assistance, from policy discussions, to training, to communications efforts and management priorities.

Birthspacing Programmatic Review
Summary Matrix of Key Findings from Data Collection and Analyses

Issue/Question	Finding		Information Source
Countries with birthspacing referenced in policies, procedures, and standards	*Some* (13 of 17) *None* (4 of 17)	76% 24%	Birthspacing review questionnaires/ country reports from 17 countries
Countries with stated birth interval in policies and standards	*2 years* (7 of 17) *2–3years* (3 of 17) *3+ years* *None* (3 of 17)	41% 18% 0 18%	Birthspacing review questionnaires/ country reports from 17 countries
Countries that link mortality with birth intervals at policy level	1 of 17	6%	Birthspacing review questionnaires/ country reports from 17 countries, and country visits
Countries with service delivery protocols, standards, and guidelines linking birth intervals to mortality reduction		0	Birthspacing review questionnaires/ country reports from 17 countries, and country visits
Family planning communications with any birthspacing content (n = 4,353 items collected worldwide)	*Some* *None*	6% 94%	JHU/CCP communications database
Inclusion of specific health risks within communications that have birthspacing content (n = 801 items collected worldwide)	*Maternal mortality* *Infant mortality* *High-risk pregnancy* *Adolescent pregnancy*	4% 3% 5% 2%	JHU/CCP communications database
Most common issues countries report as affecting women's birthspacing choices	*Cultural* *Knowledge* *Gender Inequality* *Contracep. Supply*	82% 76% 76% 71%	Birthspacing review questionnaires/ country reports from 17 countries, and country visits
Leaders' awareness of health implications of birthspacing	*Generally* *Somewhat* *None*	59% 18% 24%	Birthspacing review questionnaires/ country reports from 17 countries, and country visits
Common needs identified in countries to strengthen birthspacing for health improvements	*New/spec. policy* *Service protocols* *Interval standards*	71% 53% 53%	Birthspacing review questionnaires/ country reports from 17 countries, and country visits
Use of survey data used to monitor birthspacing for programs in countries	*Yes* *No* *No response*	12% 53% 35%	Birthspacing review questionnaires/ country reports from 17 countries, and country visits
Portion of training materials (10 sets) that cover health benefits derived from birth intervals	*Do* *Do not*	44% 56%	Training materials review by C. Davis, Johns Hopkins University (JHU)
Training material (10 sets) cover birthspacing counseling for zero parity women	*Do* *Do not*	0 100%	Training materials review by C. Davis, JHU

I. INTRODUCTION

BIRTHSPACING: THE ISSUES

Recently, the topic of birthspacing and the role of timing births or pregnancies in maternal and child health have received increased attention. A group of United States Agency for International Development (USAID)'s cooperating agencies (CAs) began a discussion around the topic of birthspacing and has been reviewing the implications of new research. In a coordination role, the CATALYST Consortium convened a series of birthspacing meetings with CAs. Among the questions raised was the need to determine how well service delivery programs are or have been informing families about the health benefits of birth intervals. Another question being considered was the current role of birthspacing within basic service delivery efforts in countries. In essence, fundamental questions remained about the extent to which the results of recent research concerning the health benefits of longer birth intervals are reflected in programs internationally.

Examples of Recent Research

Birth intervals have long been associated with improved reproductive health, and the relationship of birth intervals that are less than 24 months to increased risks for maternal and child mortality have also been documented. However, over the past few years, findings from new research provide additional information on the critical role of child spacing in maternal and child health and nutrition. Some of these analyses relate longer intervals between births to significant reductions in mortality and morbidity.

For example, a 2000 study using Demographic and Health Survey (DHS) data from 18 countries and assessing the outcomes of more than 430,000 pregnancies found that children born three years or more after a previous birth are healthier at birth and more likely to survive at all stages of infancy and childhood through age 5 (Rutstein 2002). The difference in the risk of death was significant in 17 of the 18 countries analyzed and the increased risk of death was substantial. When compared with children born less than two years after a previous birth, children born after a three to four–year interval were found to be 1.5 times more likely to survive the first week of life, 2.2 times more likely to survive their first 28 days, 2.3 times more likely to survive the first year, and 2.4 times more likely to survive to age 5. The same study concluded that two-year birth intervals are associated with higher child mortality risks than births occurring at 36–month intervals and represent a 26 percent increased risk of death for newborns, a 43 percent increased risk of death in infants, and a 51 percent increased risk of death among children under 5.

> *How do you know lengthening birth intervals can reduce mortality? I haven't seen the international research and even if it was the case in other countries, there are so many reasons why children die. How can birth intervals affect mortality?*
>
> Reproductive health specialist, national health project, Uganda, 2004

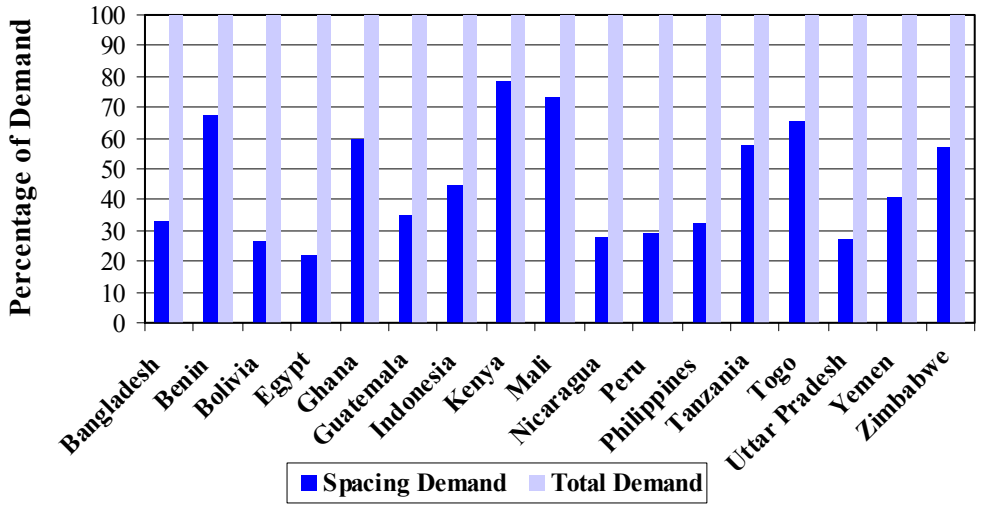
Another 2000 study, assessing outcomes from more than 1 million pregnancies, found that extremely short birth intervals (less than 15 months) were associated with a 150 percent increased risk of maternal death. The same research found that short intervals were also associated with increased maternal health complications: third trimester

bleeding (70 percent); premature rupture of membranes (70 percent); puerperal endometritis (30 percent); and anemia (30 percent) (Conde-Agudelo and Belizan 2000). Similarly, recent (2002) research in Latin America, using data from 1,080,650 pregnancies, found that birth intervals of 20 months or less were associated with increased risk of early preterm delivery, fetal death, low birth weight, early neonatal death, and low Apgar score (Conde-Agudelo and Belizan, unpublished). Recent studies conducted in the United States and Northern Europe also found that short birth intervals were associated with a range of adverse perinatal and neonatal outcomes (see Fuentes-Affleck and Hessol 2000; Zhu, Rolfs, Nangle, Horan, et al. 1999; Zhu, Haines, Le, McGrath-Miller, and Boulton 2001; and, Smith, Pell, and Dobbier 2002). In combination, the findings from these studies show the substantial role of birthspacing in reducing health risks and mortality for women and children (see also Setty-Venugopal and Upadhyay 2002).

The Nature of Demand and Need for Birthspacing

When looking at recent data from the DHS from a range of developing countries in Africa, Asia, and Latin America, it is clear that the overall demand for birthspacing is substantial. For example, the portion of the total demand (all married women of reproductive age [MWRA]) for family planning due to spacing ranged from about 22 to 78 percent of total demand in 14 of 16 countries examined (see figure 1). Similarly, the portion of total unmet need among all MWRA for family planning due to spacing is also substantial, ranging from about 25 to 66 percent of total unmet need.

Figure 1
Total Demand for Family Planning and Portion of Demand From Spacing Among All Married Women of Reproductive Age
(17 Countries)

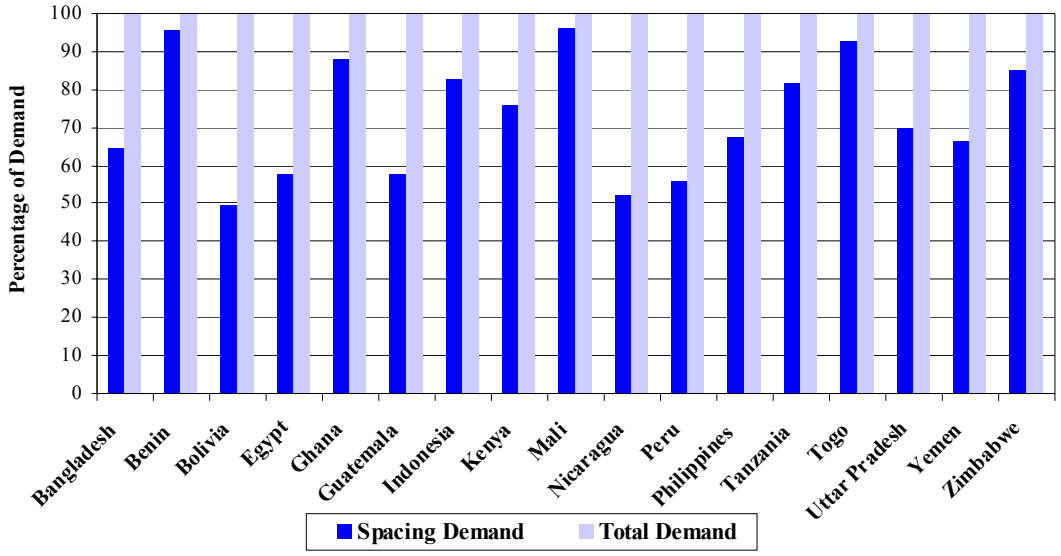


Source: W. Jansen, University of North Carolina-Chapel Hill, 2002 analysis of recent DHS data

However, when one looks at younger age cohorts alone, spacing is by far the main reason for any demand for family planning. For example, among married women who are 29 years or younger, the portion of the total demand for family planning for spacing reasons varied from about 66 percent to over 90 percent in 12 of 17 countries examined. In the

other five countries, the demand for birthspacing represented at least 50 percent of the total demand for family planning among women who were less than 30 years old. A similar pattern emerged for married women 29 years of age or younger for the unmet need for family planning due to birthspacing: the birthspacing portion of the total unmet need ranged from about 50 percent to over 90 percent of the total unmet need in the 17 countries (see figure 2).

Figure 2
Total Demand for Family Planning and Portion of Demand From Spacing Among Married Women of Reproductive Age, 29 Years or Younger



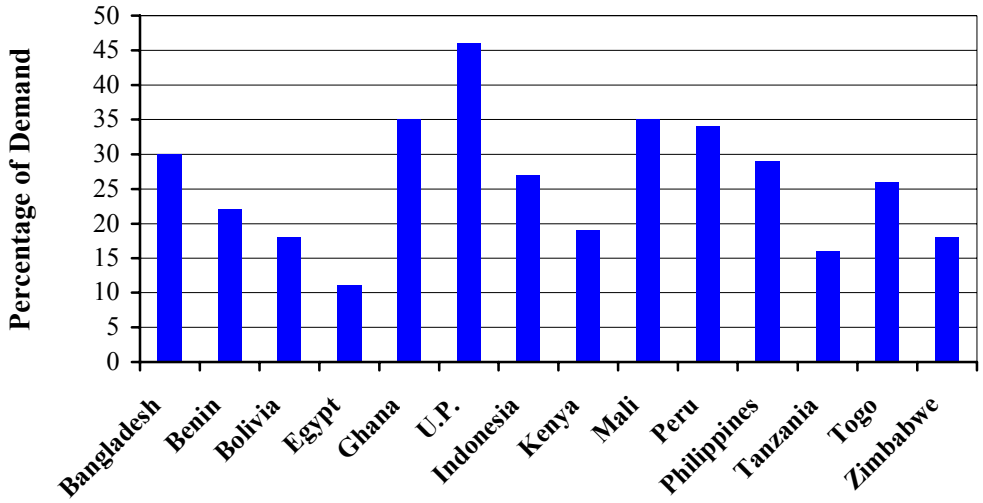
Source: W. Jansen, University of North Carolina-Chapel Hill, 2002 analysis of recent DHS data

Assessments of DHS data from developing countries also show that younger, lower parity women have the highest demand and need for birthspacing. A multicountry analysis shows that between 90 and 100 percent of the demand for spacing in the 15 to 24–year age cohort is made up of women with a parity of two or less. In the 25 to 29–year age cohort, the portion of the total demand for spacing from two or less–parity women remains substantial, usually between 50 and 90 percent (Jansen et al. 2002).

> *There is absolutely zero demand among women for spacing before the first birth.*
> Director of service delivery organization, Uttar Pradesh, India, 2004

Interestingly, in each country thus far examined, the demand for spacing exists even among zero parity women who are interested in postponing a first birth. The largest portion of the total demand for birthspacing that came from zero parity women occurred in the youngest age cohort (15–19 years of age)—ranging from a low of about 5 percent to a high of 46 percent (see figure 3 on the following page). Significantly, DHS data from 17 countries show that in the 15 to 19–year age cohort, there was some unmet need for birthspacing among zero parity (Jansen et al. 2002).

Figure 3
Total Family Planning Demand for Spacing
Among Zero Parity Women in the 15–19 Age Cohort
in Selected Developing Countries



Source: W. Jansen and D. Frick, University of North Carolina-Chapel Hill, 2002–2003 analysis using recent DHS country data sets

Magnitude of the Birthspacing Issue

Given recent research that highlights the significant contributions of birth intervals in reducing morbidity and mortality among women and children, birthspacing has the potential of being a potent element in program efforts to bring about improvements in maternal and child health. Demand for birthspacing, particularly among younger, low parity women, is substantial. Unfortunately, much of that existing demand or need for birthspacing remains unsatisfied.

Indeed, short birth intervals continue to be seen in substantial numbers in a wide range of countries. In fact, the majority of nonfirst births in developing countries occur after too short an interval. Data from 55 developing countries show that 57 percent of women have spaced nonfirst births shorter than three years, and 26 percent have spaced births less than two years apart. In five Latin American countries, among adolescent girls with more than one birth, approximately 95–97 percent of those aged 15–19 have birth intervals of less than three years (Setty-Venugopal and Upadhyay 2002).

Clearly, many births in the developing world are occurring after short intervals with increased mortality and morbidity risks for women and children. To achieve the health benefits that longer birth intervals could make to mortality and morbidity reduction objectives, the unmet need for birthspacing will have to be better addressed. This assessment was designed to examine how birthspacing efforts are addressed within service delivery efforts in the health sector and to determine what opportunities may exist to better realize the potential contribution healthier birth intervals could make to improved maternal and child health.

DESCRIPTION OF ASSIGNMENT

The scope of work (see appendix A) for the USAID Office of Population and Reproductive Health (GH/PRH) review of birthspacing indicated that two broad questions should be addressed:

- How effectively are programs educating families, providers, and policymakers about birthspacing as a maternal and child health intervention?

- What program improvements are needed?

Specifically, the review should

- document current birthspacing services, counseling, education, outreach, and other activities in select countries, that is, the strategies and approaches used to

  - educate women, men, providers, and policymakers about the health, nutritional, and other benefits of optimal birthspacing; and

  - deliver the appropriate services that help women (including zero parity women) achieve the birth intervals they want;

- review birthspacing training and educational materials, including communication/behavior change materials and programs, job aids, tools, and community outreach materials;

- identify gaps in programming; and

- make recommendations to improve birthspacing counseling, outreach, client and provider interaction, behavior change communication, research, monitoring and evaluation, and policy.

The list of persons contacted is found in appendix B.

METHODOLOGY FOR DATA COLLECTION

The assessment team developed a multifaceted methodology for the collection of information for the assessment of birthspacing in programs. Information gathering included three general efforts focusing upon activities in-country, communication materials generally available, and examples of training materials submitted by CAs. Standard questions were applied to each effort. Appendix C contains the country data collection instruments.

For country-level data collection, USAID asked the PRIME, CATALYST, and Advance Africa projects as well as EngenderHealth to assist in gathering information within countries. CA staff used the standard questionnaire instrument and assessment guidelines to gather information from informants in-country and to report the findings.

A two-tier approach was adopted for information gathering from countries. Tier 1 consisted of countries in which the information provided came mainly from the CA staff currently working in the countries and their counterparts. CA staff was involved in both the collection and submission of data in a tabulated format.

Table 1
Countries Included in the Assessment

Tier 1	Tier 2
Bangladesh	Bolivia
Nepal	India
Egypt	Nigeria
Paraguay	Pakistan
El Salvador	Peru
Ethiopia	Uganda
Guatemala	
Jordan	
Kenya	
Rwanda	
Yemen	

Additionally, some countries were included in tier 2 and subjected to indepth data collection, with a wider range and larger number of informants. Team members also visited tier 2 countries to interview people and collect program information. Information in tier 2 countries was gathered from individuals within organizations (such as ministries of health, nongovernmental organizations [NGOs], family planning associations, service delivery groups, and commercial service providers). The intent was to gather sufficient information to allow as complete a representation of the most popular sources of family planning and other reproductive health services as possible. In the most prevalent service delivery networks, the pool of potential informants included senior program managers, midlevel managers, and frontline service providers.

Collecting information involved the assistance of the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (JHU/CCP), where the team visited and interviewed staff members. Examples of specific communications materials were reviewed and the JHU/CCP communications materials database was used to survey available examples of communications materials. Country-specific communication information also was collected from the countries included in the sample. Members of the assessment team also conducted information-gathering visits to five countries (Bolivia, India, Nigeria, Peru, and Uganda).[1]

[1] The review of training materials was conducted by Chris Davis at JHU and relied on examples of training materials provided by projects or CAs.

II. STATUS OF BIRTHSPACING EFFORTS IN COUNTRY PROGRAMS

GUIDANCE FROM POLICY, NORMS, AND STANDARDS

At the sectoral level, 13 of the 17 (76 percent) countries examined have health, reproductive health, or family planning policies and policy documents that acknowledge a role for birthspacing in family planning service delivery. National-level policies in four countries do not mention birthspacing significantly. Typically, policies that mention birthspacing link it to improvements in the general health of mothers and children. Most do not relate birth intervals to any specific health risks. Similarly, in policies with a birthspacing element, two (Uganda and Jordan) related birthspacing and birth intervals to potential reductions in child mortality. A clear linkage between birthspacing or birth intervals and maternal mortality also was absent in more than 90 percent of the policy or norms reviewed from the countries in the sample. The team found that birthspacing is usually dissociated from specific objectives in policies, service standards, program management norms, and practice guidelines that pertain to mortality or morbidity reduction.

Of those that mention birthspacing in policies, seven (slightly more than half) mention a birth interval of two years. Three have a two to three–year interval, and three do not specify an interval. No examples were found that discussed birth intervals greater than 36 months. When asked about the origin of a given interval or rationale in existing policies, the most common response cited World Health Organization (WHO) guidelines as having influenced the policies or norms that do exist. Interestingly, when birthspacing is included in policies, standards, or service delivery protocols, the benefits credited to birthspacing also include such rationales as higher quality of life in the family, opportunities for the wife to spend more time with her husband, less economic burden on the household, more educational opportunities for the children, and smaller family size. It is common for any one of these other themes to receive equal treatment in guidelines or policies. General health issues, consequently, usually are just one of several rationales for birthspacing in norms or guidelines.

Service delivery norms and practices do evidence some effort in selected countries to reach younger women, particularly after the first birth. More examples exist in NGO service delivery contexts than in the public sector (there have been public sector communication programs in Ghana, Nicaragua, Bangladesh, and Jordan). Among program managers and service providers interviewed, it was common for assumptions to be made about what women want. The team encountered stereotypes about zero parity women in each country visited.

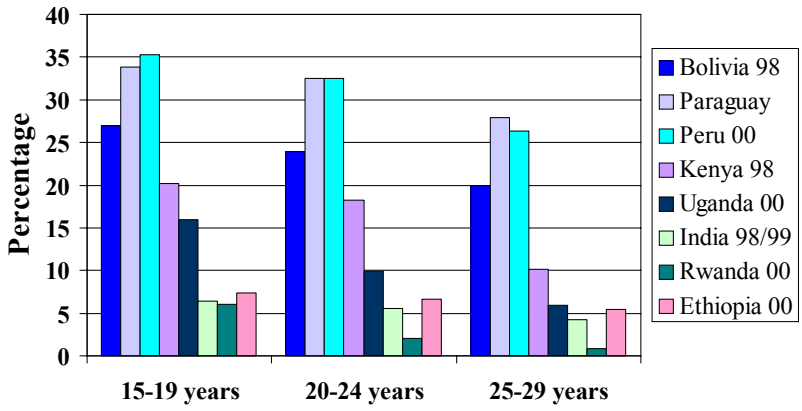
For example, when asked about any effort to offer services to newly married women who do not yet have any children, a common response was that "newly married women do not want to use contraceptives because they want to have a child right away."

> *We do try to reach young people with family planning services; but those without children are not part of this target population.*
>
> Manager in an NGO providing family health services, Uganda, 2004

Indeed, there was a popular image among managers and providers in some of the countries visited that it was not worth the effort to try to reach young

zero parity married women, citing a lack of any perceived demand. Recent DHS data from these countries (see figure 4), however, indicates that some young women report first use of contraception having occurred when they did not yet have any children.

Figure 4
Percentage of Women Reporting First Use of Contraception at Zero Parity by Age Cohort



Source: Macro International DHS data sets

In situations where there are political, religious, cultural, or other sensitivities associated with the term family planning, the term birthspacing was a label often applied to contraceptive service delivery for any reason. Uganda, Nigeria, Peru, and Bolivia, for example, tended to use the term birthspacing for any contraceptive service. In such settings, the health benefit and health rationale for birth intervals appears to be very diluted and policies contain certain internal inconsistencies. An illustration of an internal inconsistency was for a birthspacing policy to include such indicators as total contraceptive prevalence (of any type) or total fertility rates as a measure of birthspacing. In India, the term birthspacing was used to be synonymous with any short-term method, even if that method was being used to have no more children.

USE OF INFORMATION, EDUCATION, AND COMMUNICATION (IEC) AND BEHAVIOR CHANGE COMMUNICATION (BCC) IN COUNTRIES

The following matrix presents data from the CA country reports on programs to "educate women and men (including zero parity women and women in the postpartum/antenatal period) and/or providers about the risks of too short intervals and the health, nutritional, and other benefits of longer birth intervals." Although the scope of work was seeking the extent to which relevant CAs, private voluntary organizations (PVOs), NGOs, and ministries of health implemented such programs, except for countries in which JHU/CCP has had national programs (Jordan, Bangladesh, Nepal, and Egypt), the data presented by the CA country reports do not allow comments on the extent (coverage) of such programs or their effectiveness. Except for the JHU/CCP programs, the campaign coverage of mass media programs is unknown, as is the percentage of the population covered in client education or community education. See section IV for a review of birthspacing in the two major communication and behavior change projects of JHU/CCP.

Table 2
Programs To Educate Women and Men

Family Planning/ Birthspacing Programs	IEC/BCC Programs		
	Mass Media (campaign exposure unknown)	**Client Education** (percentage of population reached unknown)	**Community Outreach** (percent of population reached unknown)
None on FP or Birthspacing	Bolivia Peru El Salvador Uganda Guatemala Yemen Paraguay	Yemen	Yemen
Have FP; None on Birthspacing	Egypt	Paraguay (limited)	Paraguay (limited) El Salvador
Have FP; Have had Birthspacing for Two to Three Years	Ethiopia Jordan Kenya (limited) Pakistan Rwanda	Ethiopia Egypt El Salvador (limited pilot) Jordan Kenya Pakistan Rwanda Uganda	Ethiopia Egypt Jordan El Salvador (limited pilot) Kenya Pakistan Paraguay (limited)
Have FP; Have had Birthspacing for Three to Five Years	Bangladesh Nepal Nigeria India	Bangladesh Bolivia (NGO pilot) Guatemala Nepal Nigeria India (limited) Peru (pilot in one region)	Bangladesh Bolivia (NGO) Guatemala Nepal Nigeria India Peru (pilot in one region)

USAID CAs have begun education on birthspacing in many countries, often on a pilot basis. In Peru, the CATALYST Consortium has supported the development of a birthspacing program in one NGO in one underserved department with 3 percent of the nation's population. Birth intervals are short in the region and maternal mortality is high. This program, with Asociación Para el Desarrollo Amazónico Rural (ADAR), informs community leaders, training providers, and community outreach in 46 communities in the region of Loreto. ADAR has developed and distributed a bulletin, broadcast radio spots, conducted home visits, and counseled men, women, and adolescents. Although activities have been important, the scale and coverage have been limited and it is questionable whether the program can continue when CATALYST funding ends.

In Bolivia, CATALYST developed a 19–page, color, client brochure, *Embarazo saludable, seguro y feliz* (*A Healthy, Safe and Happy Pregnancy*), half of which is devoted to birthspacing, including the health consequences that could occur if births are spaced too closely. Through PROCOSI, the Bolivian network of health NGOs and PVOs, CATALYST has distributed the brochure to NGO/PVO service sites nationwide. This brochure is illustrative of some of the more recent efforts to make information on the health effects of birthspacing more available. CATALYST will be formally evaluating this brochure in the next several months.

> *Yes, birthspacing is a part of our family planning services. I tell women that they should space children at least two years apart so that their bodies can "rebuild" and to think about the education needs of their children.*
>
> Health care provider, India, 2004

The CATALYST CA report indicates that in Egypt there have been national television campaigns that encourage spacing, but they do not address at risk pregnancies, the optimal birthspacing period, or postpartum contraception. In other countries, national programs focus on birthspacing for reasons appropriate to that country. The PRIME CA report indicates that in Rwanda, IEC/BCC is directed toward birthspacing due to genocide-related sensitivities.

It is noteworthy that in seven countries there is no mass media on family planning at all, for spacing or limiting. In a number of these countries, there is a major lack of information about planning and spacing one's children. For example, the El Salvador National Family Health Survey 1998 (FESAL 98) indicated that 1 in 4 women who were asked, "When you first became pregnant, were you aware you could become pregnant?" responded that they did not believe so. Thirty-five percent of those whose first pregnancy occurred when they were less than 15 years old stated that they were not aware. Almost 25 percent of those between 15 and 19 years at the time of the first birth were not aware. The Bolivia 1998 DHS indicates that 27 percent of women in union under 30 years did not use a method because they did not know one; in Guatemala, the figure was 28 percent, and in Peru, it was 10 percent.

Bangladesh and Jordan appear to be exceptions among the 17 countries reviewed, in that their programs have directed efforts toward newly married and zero parity women. (Other countries that have targeted youth and zero parity women include Nicaragua and Ghana; see section IV.) In general, however, zero parity women are not included in efforts to educate women about postponing a first birth. In many countries (Jordan, Egypt, India, Pakistan, Kenya, and Nigeria), there are strong cultural expectations for a couple to conceive immediately after marriage. In other countries (Bolivia, Peru, Guatemala, and El Salvador), many women do not marry or live with their husbands until the woman is pregnant.

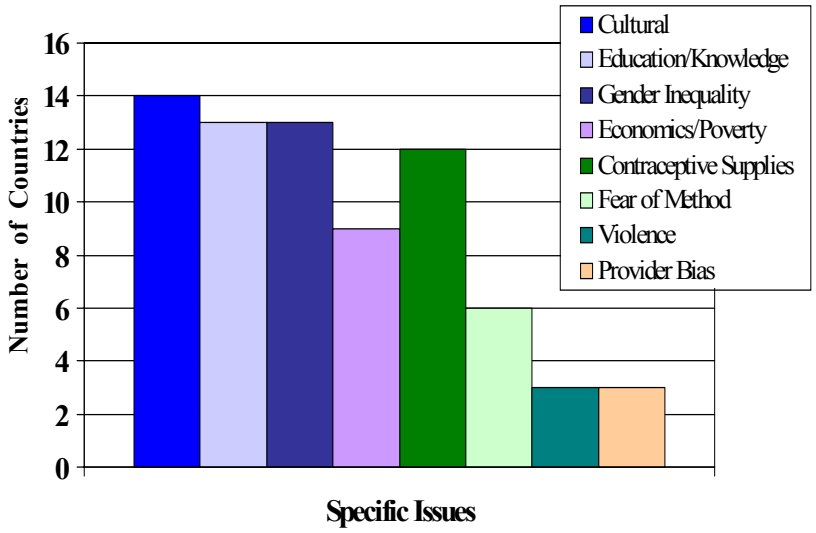
There is, however, global data on the fact that many first births are not wanted. For example, FESAL 98, in a module examining the circumstances of first births, indicates that 66 percent of ever-pregnant women identified their husband/life partner as the man responsible for their first pregnancy. Among the other 33 percent asked about the reactions of the father of the baby, 14 percent indicated that the father rejected the pregnancy. FESAL 98 indicates that 15 percent of first births were unwanted (in contrast to planned or wanted).

Various programs are promoting spacing for a variety of reasons (including the health benefits for mother and child). In Nepal, Bolivia, and Peru, birthspacing messages promote the economic benefits of spacing. Peruvian messages, building upon focus groups with men and women, counsel men and women that through spacing, women will have more energy to be sexually responsive to their partners.

ISSUES THAT AFFECT WOMEN'S ABILITY TO ACHIEVE BIRTH INTERVAL PREFERENCES

There are many major issues that affect women's ability to achieve the birth intervals they would prefer. The case study on birthspacing in Bolivia (final appendix) gives an example of the issues in one Latin American country. The issues, however, are quite common across countries. The CA country reports identified the following issues; data supporting their conclusions come from a variety of sources, including the DHS.

Figure 5
Issues Affecting Access or Ability To Exercise Birthspacing Choices
(Number of Countries)



Source: Assessment team's analysis of responses to birthspacing review questionnaires and CA country reports

Cultural Traditions and Norms

All 17 CA country reports identified cultural factors that impeded women. All reports described reasons why contraception is seldom used before a first pregnancy, regardless of the age of the woman. In some countries, marriage or living together does not take place until the woman is pregnant. In many countries, societies assume pregnancy will immediately follow marriage and there is tremendous pressure on the woman to immediately produce a child, preferably a son. For example, the report on the CATALYST focus groups on birthspacing in Egypt quoted one 22–year old woman as saying that her mother-in-law told her, 1 month after delivery, "Collect your strength and bring him a brother before you get up from this bed you are sleeping on." In that study, all urban nonspacers in Minia, Upper Egypt, declared that "their families want their children to be born right after each other," which means that they are expected to become pregnant after the 40th day of delivery.

> When asked if there was a specific programmatic effort to reach young, newly married couples who have not yet had children, a senior manager of family planning services in Nigeria stated, "No, our culture doesn't support delaying the start of a family; the pressure to have a child after marriage is too high."

Religion was cited in many countries as an issue affecting women's choices related to the timing of pregnancies. In 7 of the 34 DHSs conducted in the last five years, over 10 percent of the respondents cited religious prohibition as a reason for not using contraception.

Gender Inequality, Including Intimate Partner Violence

Although the degree of gender inequality is often a cultural issue, gender inequality is so important in the ability of a woman to space pregnancies that it is condensed as a separate issue in this report. As contained in the Jordan DHS report (2002), "A woman's ability to use contraceptive methods to control her fertility is likely to be affected by her status and degree of empowerment." Gender inequality and women's low status leave them vulnerable to violence. A Family Health International (FHI) report on abused women quotes a gender consultant with the International Planned Parenthood Federation (IPPF) in London as stating, "The threat or fear of violent behavior prevents women from protecting themselves adequately from pregnancy, abortion, and sexually transmitted diseases… It leads women to defer to male decision-making on what form of contraception they are allowed to use, which may not be what is effective or right for them."[2]

A critical factor in this inequality can be sexual abuse, including intimate partner violence. A number of countries report such abuse, particularly for adolescent and younger women. A 1997 FHI study in La Paz, Bolivia, reported that a third of women in union were forced to have sex by their partners when they did not want to, generally when the man was drunk. In El Salvador in 1998, 6 percent of all women aged 15–49 years who reported having had sexual intercourse at least once were asked if they were ever forced by someone to have sex. Six percent answered affirmatively; of those, 60 percent were forced when they were between the ages of 10–19 years.[3] Reports on CATALYST focus groups in Bolivia and Peru recount similar pictures of forced sexual relations: "Men exert control and impose their will when it comes to sexual relations, regardless of whether or not the woman wants to engage in sexual relations for fear of becoming pregnant."[4]

Intimate partner violence is an important cause of unintended pregnancies. The case study on Bolivia describes the role of physical and sexual abuse in impeding a woman from spacing as she would like in Bolivia. The Population Report, *Ending Violence Against Women*, cites a large-scale survey among married men in Uttar Pradesh, India,

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[2] Family Health International, *Abused Women Have Special Needs*, FHI web site document found at http://www.fhi.org/en/RH/Pubs/Network/v18_4/NW184ch4.htm.

[3] Encuesta Nacional de Salud Familiar 98, National Family Health Survey, Final Report, República de El Salvador, CDC, April 2000, page 193.

[4] CATALYST Consortium, *Bolivian Focus Groups on Birthspacing, Qualitative Study in Bolivia*, June 2003, page 4.

that demonstrated directly that "forced sex can lead to unintended pregnancies. Men who admitted having forced their wives to have sex were 2.6 times more likely than other men to have caused an unplanned pregnancy."[5]

Intimate partner violence occurs throughout the world. The Population Council, in a 2003 review of nonconsensual sexual experiences of young people (ages 10–24 years), indicates that in studies of first sex (among those who have ever engaged in sexual relations), 15–30 percent typically indicate that the experience was forced.[6] "Nonconsensual sexual activities are most likely to occur in familiar settings (such as the neighborhood, home or school), in the course of routine activities, and are largely perpetrated by those with whom the young person is acquainted."[7] The Population Council review concludes, "substantial sexual coercion against women occurs within marriage. An analysis of over 50 population-based surveys found that approximately 10–50 percent of adult women around the world reported having been physically assaulted by an intimate male partner (including their husbands) at some point in their lives." [8]

Despite the common global pattern of sexual violence leading to unwanted pregnancy, the availability of emergency contraception is extremely limited. In the 16 countries consulted for this review, emergency contraception is openly available in none:

- emergency contraception is within public sector norms, but not promoted (El Salvador);
- emergency contraception is available in the private sector, to some degree, for those who know enough to ask for it (Bangladesh, Bolivia, Ethiopia, Nigeria, Peru, Pakistan, and Rwanda);
- emergency contraception is not readily available (Guatemala, Jordan, Kenya, Nepal, Paraguay, and Uganda); and
- availability is unknown (India, Egypt, and Yemen).

Lack of Knowledge

A lack of knowledge about methods and about the source of methods continues to hamper women from spacing their children. For instance, in the Bolivia 1998 DHS, 27 percent of women under 30 indicated that they lacked knowledge of methods. In Guatemala in 1999, the rate was 28.1 percent; in Nigeria in 1999, it was 15.6 percent.

[5] Population Reports, *Ending Violence Against Women*, Series L, Number 11, Population Information Program, JHU/CCP, December 1999.
[6] Shireen J. Jejeebhoy and Sarah Bott, *Non-consensual Sexual Experiences of Young People: A Review of the Evidence from Developing Countries,* Population Council, Regional Office for South and East Asia, 2003.
[7] Ibid.
[8] Ibid.

Myths, Fears, and Health Concerns

Myths and fears about side effects and health concerns continue to limit many women from spacing children effectively. In 8 of the 14 countries for which there are data on reasons for nonuse, more than 10 percent of the women cited myths, fears, and health concerns as their reason for nonuse of contraception. Thirty percent of women under 30 in Uganda in 2000 and 28 percent of women under 30 in Bolivia cited such concerns in 1998. In El Salvador in 1998, the rate was 14 percent, and in Peru, for side effects alone, it was 27 percent.

Lack of Contraceptives

Problems with the contraceptive supply were identified in all but 3 of the 16 countries in this programmatic review: Egypt, Jordan, and Nigeria. In Bangladesh, Bolivia, El Salvador, Ethiopia, Guatemala, Kenya, Nepal, Peru, and Uganda, team members observed or the CA country reports indicated that there are chronic shortages or stock outs of one method or another. In India, where sterilization is the most common contraceptive method, there is a question of supplies for spacing. In Pakistan and Yemen, there is a lack of services as well as spacing methods. In Rwanda, 40 percent of health facilities are affiliated with the Catholic Church and offer only traditional methods.

Team members observed shortages of Depo-Provera, popular because it is a discreet method that no one except the woman and provider need to know about, in 3 of the 4 countries visited: Peru, Bolivia, and Uganda.

Method Failure

In many countries, women are trying to space pregnancies, but their method fails and they become pregnant. The problem is most acute in countries that continue to have a high percentage of women using traditional methods. For example, in Jordan, 15 percent of women use traditional methods (withdrawal: 9.3 percent; periodic abstinence: 5.2 percent; other: 0.1 percent). The first year discontinuation rate for all methods due to method failure is 10.5 percent; for withdrawal, it is 16.4 percent; and for periodic abstinence, it is 27.9 percent.

First-year method failure rates in other selected countries include Guatemala: 19 percent for periodic abstinence; Kenya: 14 percent for periodic abstinence; Paraguay: 18.5 percent for periodic abstinence and 13 percent for withdrawal; and Peru: 17 percent for periodic abstinence and 13 percent for withdrawal.

As the Bolivian case study relates, method failure is common in contexts of high use of traditional methods combined with acknowledged high rates of intimate partner violence, including forced sexual relations. With traditional methods and the use of condoms, women are dependent on their partner's compliance.

Quality of Services: Provider Bias and Poor Counseling

A number of CA country reports (Egypt, Guatemala, Jordan, Kenya, India, Nigeria, Peru, and Rwanda) identified provider bias and/or poor counseling as reasons why women did

not space children more effectively. Many country reports noted a provider bias against young women, particularly zero parity women.

> *I tell women after they marry to hurry up and have their children so that they can get a tubal ligation and be finished with having children.*
> Health care provider, India, 2004

Problems With Access to Services

The majority of CA country reports noted that women had trouble accessing available services because of physical or economic constraints; Egypt and Jordan were exceptions in this regard. Two CA country reports, Pakistan and Yemen, moreover, reported that there is a scarcity of services themselves.

Poverty

In 9 of the 17 countries, poverty or a lack of economic resources was identified as a barrier or constraint to some women's ability to space births or time pregnancies when they want. Respondents in India and Uganda, for example, stated that women from poor households were more likely to experience early marriage and first pregnancies when they are younger than 18 years old. Poverty also is often linked with low levels of education and less information about family planning or health generally.

Some program managers cited poverty as a reason why some poor households do not access private sector providers for such preventive services as family planning. However, DHS data commonly indicate that the cost of contraceptives is not a significant reason for nonuse.

AVAILABLE RESEARCH ON PLANNING AND SPACING BIRTHS

Aside from DHS data, virtually no nationally representative research on birthspacing practices and preferences was found or reported for the countries examined. Research on birthspacing services or birthspacing practices at the family level that does exist tends to be relatively recent and often originated following the Cairo Population and Development Conference in 1994. Existing research also tends to be localized to a specific region, district, or a few service delivery facilities. Generally, the research on birthspacing is not numerous and frequently is of a qualitative nature. Research often is of a fairly narrow subject focus and does not appear to factor in a range of related variables, such as age, education, residence, or income. Consequently, the ability to comment on birth issues across countries or across areas within a country on birthspacing is limited.

When research on spacing does exist, it has received little dissemination within service delivery programs. Managers and service providers contacted tended to be unfamiliar with available research and rarely used research information for work planning or decision-making. This was a general pattern and not limited to subjects related to birthspacing.

AWARENESS OF OPINION LEADERS

Fifteen of the 17 country reports indicate that opinion leaders are aware of the health benefits of spacing but lack the resources or political will to act. The following matrix presents the country's level of awareness.

Table 3
Awareness of Program Leaders and Decision-Makers Contacted about the Relationship Between Birth Intervals and Maternal and Child Health

Insufficient Information	Not Aware	Generally Aware but No Interval Identified	Generally Aware With Two-Year Interval	Generally Aware With Three or More Year Interval
Yemen	Uganda	Bangladesh Paraguay Peru Rwanda	Bolivia Ethiopia El Salvador Guatemala Jordan Kenya Pakistan Nigeria	Egypt India Nepal

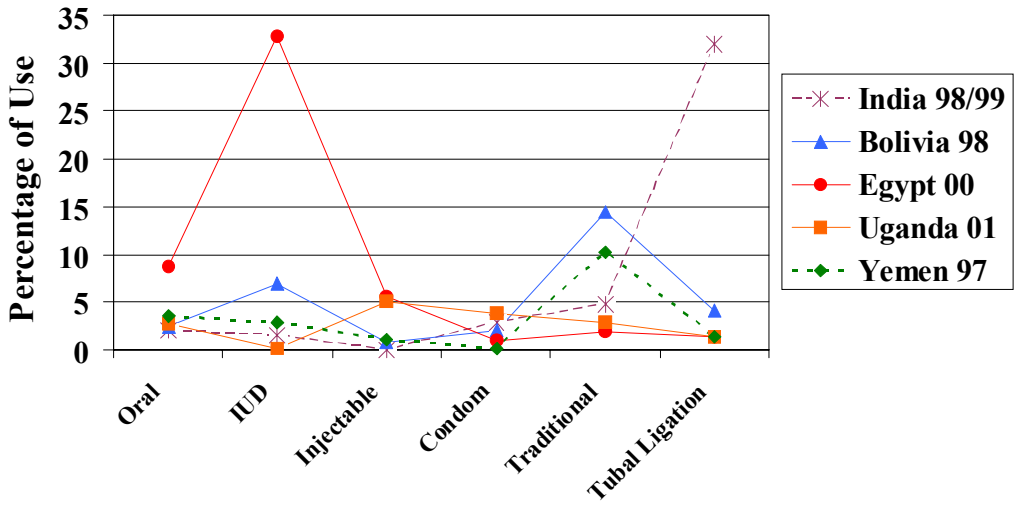
METHOD MIX AND APPARENT SUPPORT OF BIRTHSPACING

DHS data were used to examine current method mix and contraceptive use in the countries included in the assessment. The range of contraceptives available in all countries can support birthspacing choices of women. However, countries with a method mix that is dominated by a single method (such as India or Egypt) have the potential of offering weak support of a full range of services for all segments of the population that could benefit from birthspacing (see figures 6 and 7 on the following page). Single method dominance produces what some (Ross, Abel, and Abel 2004) have referred to as a narrow method mix and have identified as a factor that possibly influences a slackened pace of contraceptive use in countries over time.

> *The injectable is popular with women because it is "confidential" and can be used without the participation of the husband.*
>
> Practicing nurse-midwife, Uganda, 2004

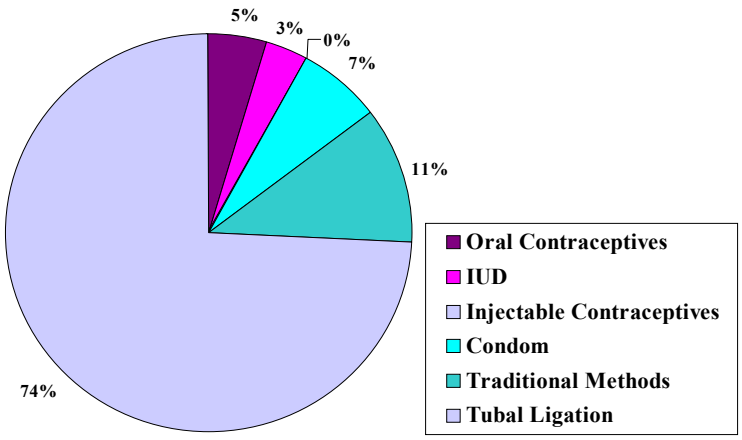
The weak support of birthspacing from a narrow method mix is particularly true for India where tubal ligation is the most prevalent method and clearly not suited for birthspacing.

Figure 6
Contraceptive Use by Method



Source: Macro International DHS data sets

Figure 7
Contraceptive Method Mix, India 1998–99



Source: Macro International DHS data sets

Interviews with service providers and program managers in India indicated that there is a tendency in some service delivery settings for clients to be urged to "hurry up and complete their family" or to view temporary methods as a service delivery "burden" because the same clients need to be seen over and over again. Additionally, in countries

or localities where gender inequities or intimate partner violence is a significant issue, any reliance on methods that are partner compliant–dependent (condoms or traditional methods) could limit the real ability of a woman to control the timing of her next pregnancy.

EVIDENCE OF SUCCESSFUL MODELS FOR INTERVENTIONS

The team searched for examples of any evidence-based programs that have improved family planning one-year continuation rates, helped women (including zero parity women) achieve the intervals/postponed births they desire, and/or effectively counseled women in the postpartum period. One country, Jordan, appears to offer one such example.

The Jordan 2002 DHS indicates that Jordan has had some success in affecting birthspacing in the country. In 1996, the government of Jordan ratified the National Population Strategy, one component of which was a National Health Program for Birthspacing. The government, in collaboration with USAID, implemented a number of significant interventions to enable women to more effectively space their children. A major national BCC program was a part; it included the national JHU/CCP program discussed below, as well as Commercial Market Strategies communication outreach activities.

From 1997 to 2001, first year discontinuation rates decreased from 48.8 to 42 percent. During that same time, birth intervals, already relatively long, increased by 18 percent. Note in table 4, however, that while there were positive increases in the percentage of short birth intervals, by 2002, almost 22 percent of birth intervals were more than four years.

Table 4
Percentage Distribution of Births in the Five Years Preceding the Survey by Number of Months Since a Previous Birth

	Number of Months				
Year	**7 to 17**	**18 to 23**	**24 to 35**	**36 to 47**	**48 or more**
1997	21.5	22.8	29.3	11.4	14.9
2002	15.2	18.3	29.1	15.8	21.6

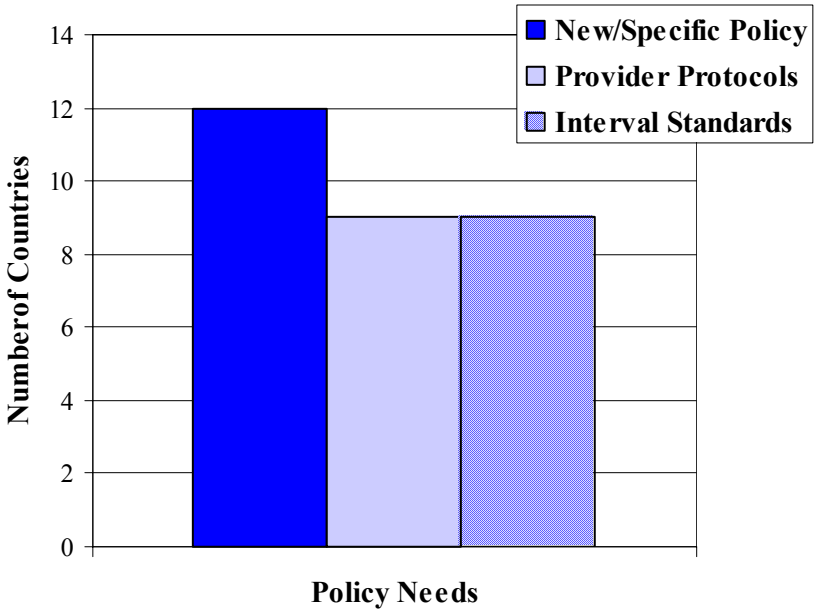
Source: DHS

Jordan is the only country for which the team has evidence-based data indicating recent improvements in first-year continuation rates or longer birth intervals (helping women to achieve the intervals they desire). The team has no data on effective counseling in the postpartum period.

POLICY NEEDS

When thinking about what would be required to improve birthspacing, the responses from 12 of the 17 countries identified a need for new or revised policies for birthspacing. Respondents from about 31 percent of the countries (4 of 13) with birthspacing included in policies felt that birthspacing needed a higher priority or greater attention from senior decision-makers.

Figure 8
Policy and Program Environment Needs
(Number of Countries)



Source: Assessment team's analysis of responses to birthspacing review questionnaires and CA country reports

Another common need, identified in 9 of 13 countries, was for increased clarity and consistency about birth intervals and the timing of pregnancies (see figure 8). Indeed, during country site visits, the team often encountered a range of responses within the same country and the same type of service delivery system concerning the recommended birth interval used with providers or clients. Respondents in nine countries identified a need for new or revised service delivery protocols for providers. This need appears to be related to the variation in responses and understanding among providers about birthspacing generally and its relationship to health risks. Interestingly, respondents in 12 of the 13 countries with birthspacing present in national policies felt that new or revised policies would be needed to strengthen the contribution of birthspacing to improvements in maternal and child health.

> *To get health professionals and senior officials to treat birthspacing as a serious intervention to reduce mortality, national experts will need to analyze country data to determine the specific health benefits that are possible in this country from birthspacing.*
>
> Health sector analyst, Uganda, 2004

Because birthspacing is generally not perceived or treated as a serious intervention to reduce mortality or morbidity in the countries visited, the team also identified a need for policies to clearly identify birthspacing as a legitimate way of reducing mortality and morbidity. Some of the health professionals interviewed, for example, stated that they did not believe that birth intervals had any relationship to mortality or morbidity. Often, the offices responsible for reducing mortality in ministries are not the same offices responsible for delivering contraceptive service delivery.

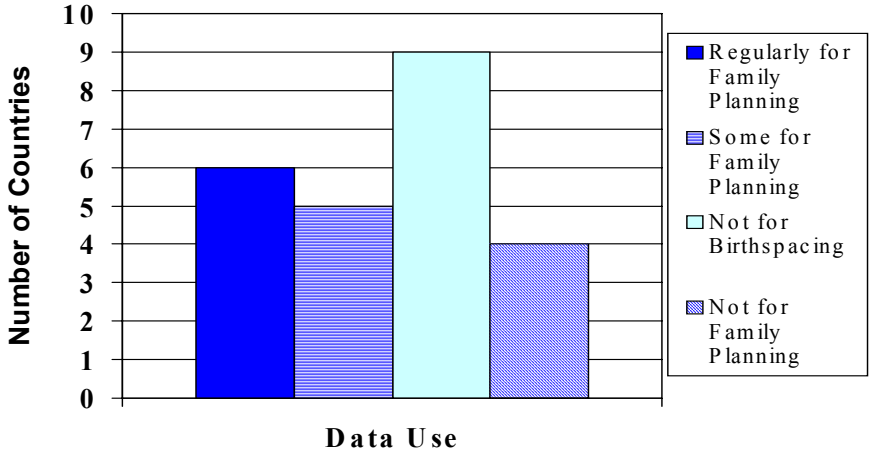
During country site visits, when some officials charged with reducing mortality were asked to list the key interventions they were pursuing to bring down infant or maternal mortality, birth intervals or birthspacing was never included. Even if asked, "what about lengthening birth intervals," these informants commonly responded that birthspacing was not an intervention of theirs or that contraceptive service delivery was the responsibility of others.

AVAILABILITY AND APPLICATION OF DHS DATA

DHS data were universally available in the countries examined. The dates of the data varied and the range of specific variables present depended upon the questionnaire or data collection modules in use at the time of the last survey.

Although available, DHS data appear to be used rarely to monitor birthspacing variables. Respondents from a majority of the countries reported no use of DHS data to monitor birthspacing (see figure 9). Interestingly, DHS data were not universally reported as being used to monitor family planning programs generally. In fact, respondents in only 6 of the 17 countries noted regular use of DHS data in family planning program monitoring, and respondents in 5 other countries reported sometime use of such data. Program performance indicators typically do not include birth intervals, and most countries do not appear to track birth intervals over time, even at the national level. DHS data about demand or preferences (family size or desired birth interval) at the client level were not known by either program managers or service providers in the countries visited.

Figure 9
Use of Data for Program Monitoring



Source: Assessment team's analysis of responses to birthspacing review questionnaires and CA country reports

The wealth of household-level survey data available about contraceptive use, desires, or preference related to birthspacing seem to be relegated to the domain of academics or researchers. Consequently, survey data do not appear to be regularly used to monitor programs or reorient the way services in the public sector are delivered. This was not necessarily the case for social marketing efforts that did report the use of consumer data

in the formulation of some aspects of developing market plans or strategies. Birthspacing, however was not a major area of attention and neither the public nor the private sector programs in most countries watch changes in birth intervals over time in relation to program performance. In most countries, birth intervals are not included among the indicators used to measure change in the health sector.

> *No, we don't look at birth intervals when we evaluate the program's progress.*
> National program manager, Nigeria, 2004

Data relevant to birthspacing are already collected as part of the standard DHS questionnaire protocol. DHS data sets, therefore, already offer program managers valuable information on birth intervals. These DHS data sets also offer program evaluators and analysts considerable opportunity to examine birthspacing issues from a variety of perspectives. However, indepth inquiries using existing data for birthspacing subjects seem relatively rare, particularly at the country or subnational level. Even in cross-country inquiries, the treatment of birthspacing topics using DHS data for sector analyses seems relatively rare.

III. REVIEW OF TRAINING MATERIALS

Between January and March 2004, a desk review of training materials was conducted to identify state-of-the-art materials as well as gaps and opportunities for improvements and the countries in which birthspacing educational materials have been used in implementing programs. CAs that are active in training health care providers were invited to submit examples of relevant training materials. To date, 10 documents (or sets of documents) have been reviewed. For the most part, materials reviewed were training curricula and related materials that are intended to provide family planning, reproductive health, and sexuality training for providers and others who deal with clients. Documents reviewed included training manuals, participant handbooks, handouts, session plans, case studies, client profiles and client situations, provider checklists, pretests, and posttests. One of the documents reviewed was a country's national family planning guidelines.

Half (5) of the document sets examined are intended for global use; the other half of the document sets are designed for use in a specific country (i.e., Afghanistan, Burkina Faso, Cambodia, the Philippines, and Zimbabwe). Documents reviewed ranged in date of publication from 1994 through 2004. Of these, one document was dated 1994, four were dated 2003, two were dated 2004, one was retrieved from the Internet in 2004, and the remaining two gave no publication date.

METHODS USED IN REVIEWING TRAINING MATERIALS

An e-mail message from USAID solicited relevant materials from CAs. The reviewer developed a checklist of questions specifically for this review. This checklist (see appendix D) served as a tool to capture information as each document (or set of documents) was reviewed. Questions on the checklist correspond to the initial list of questions proposed by the Optimal Birthspacing Initiative's program review team. Completed checklists describe the overall content and purpose of the document(s), indicate countries of use, and provide a summary of the birthspacing information found in each document (or set of documents). If a document's birthspacing messages were extensive, they were captured on an attachment to the checklist. Completed checklists are attached as an appendix to this report. Citation information was captured during the review, but it was removed from the checklists in appendix D in order to provide confidentiality for the CAs that produced the documents.

MAIN FINDINGS

This review of training materials revealed gaps or missed opportunities for conveying the concept of optimal birthspacing during training in four areas. The matrix below provides an overview by region of how extensively and effectively the topic of birthspacing was covered in the 10 sets of training materials that were reviewed, using nine indicators (see items 1 through 9 in the matrix below). Across regions, the number of birthspacing indicators covered ranged from 5 out of 9 to only 1 out of 9. Among individual training sets, coverage ranged from all 9 indicators covered (training set 5) to zero of the 9 indicators covered (training sets 2 and 3).

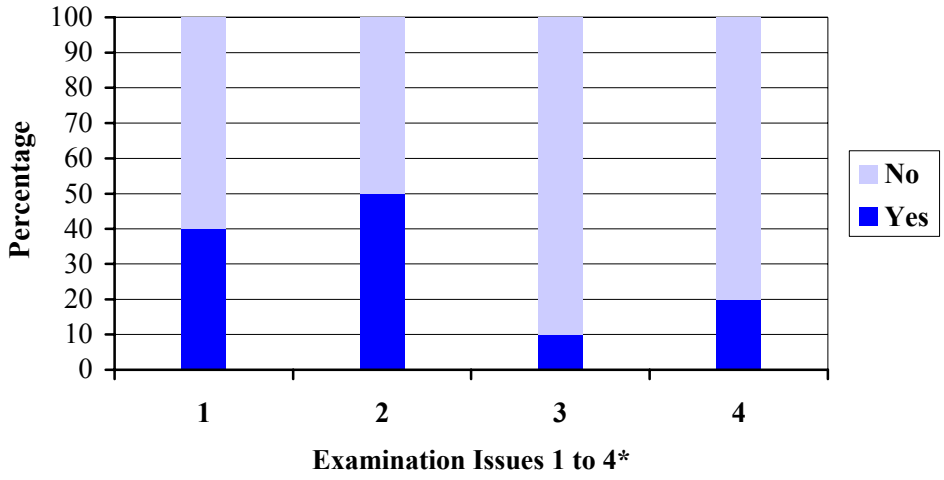
Table 5
Birthspacing Coverage in Selected Training Materials
Matrix of Summary Findings

How Effectively Was the Topic of Birthspacing Covered in the 10 Sets of Training Materials Reviewed?	Sets of Training Materials by Region									
	Global					Africa		Asia/ Near East		
	1	2	3	4	5	6	7	8	9	10
1. Birthspacing for improved health outcomes is addressed and present in tools for providers to use when counseling clients	✓				✓		✓		✓	✓
2. Discusses the potential needs of young, low parity women				✓	✓		✓		✓	✓
3. Covers the concept that birth intervals of at least three years provide optimal health benefits for women and children	✓				✓		✓	✓		
4. Includes relationships of optimal birth intervals to maternal morbidity and mortality	✓				✓		✓	✓		
5. Includes relationships of optimal birth intervals to child morbidity and mortality	✓				✓		✓	✓		
6. Existing training materials provide trainees with sufficient knowledge or skills to articulate the health benefits of optimal birth intervals to clients or staff	✓				✓			✓		
7. Includes the concept that some zero parity women are interested in postponing their first birth					✓		✓			
8. Current training materials and/or approaches provide sufficient tools or methodologies for providers or program managers to practically improve birthspacing services, particularly for young, low parity women					✓				✓	
9. Recommends counseling techniques that can be effective for contraceptive choices for zero parity women					✓					

Source: Chris Davis, JHU/CCP/JHPIEGO, 2004 review of submitted training materials

Notably, the review found that less than half (40 percent) of the documents covered the concept that birth intervals of at least three years provide increased health benefits or fewer health risks for women and children (issue 1 in figure 10 on the following page). Half of the documents examined discussed the potential needs of young, low parity women (issue 2 in figure 10). Proportionately, 10 percent of the training materials recommended what counseling techniques can be effective for contraceptive choices for the zero parity woman (issue 3 in figure 10). Among the training materials reviewed, 20 percent of the documents included the concept that some zero parity women are interested in postponing their first birth (issue 4 in figure 10).

Figure 10
Birth Spacing in Training Materials



*See discussion of issues in preceding paragraph.
Source: Chris Davis, JHU/CCP/JHPIEGO, review of submitted training materials

DISCUSSION

The documents reviewed dealt with the concept of birthspacing in a variety of ways. Some included no mention of the concept of birthspacing, while others included vague messages about births that are "too soon" or pregnancies that are "mistimed" or "too close." Several documents used birthspacing to mean family planning in general. Some documents recommended birth intervals of at least two years, while others recommended birth intervals of at least three years. One document stated that intervals of three to five years were optimal for the health of women and their children.

Birthspacing messages in these documents, for the most part, addressed the needs of adolescents, teenagers, young people, women under 18, postpartum women, and postabortion women. The birthspacing needs of postadolescent (19 or older), zero parity women were almost always overlooked.

In general, the training materials included many excellent training and counseling tools. However, many opportunities to train providers and others to deliver effective, state-of-the-art birthspacing services to clients were missed. These messages could easily be added to existing client scenarios, case studies, counseling checklists, pretests, and posttests. One document set did include two practice counseling scenarios that involved recently married women who wanted to postpone the birth of their first child but were either unsure of the contraceptive method to use or were fearful of a husband who did not agree with the woman's desire to delay childbearing.

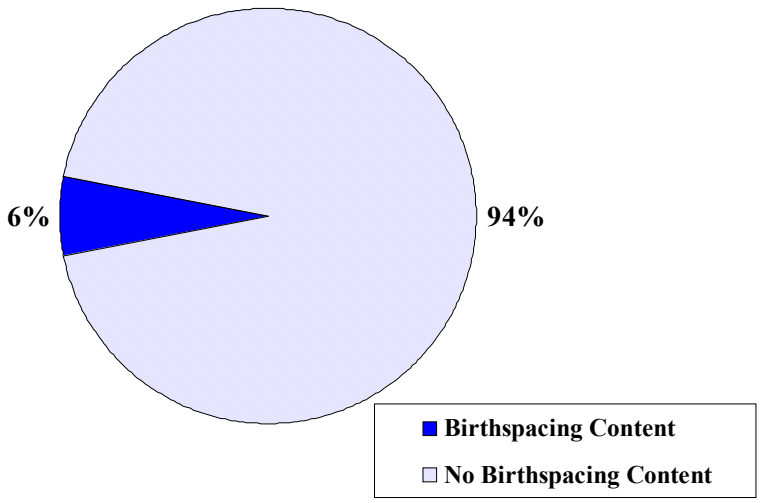
IV. STATUS OF BIRTHSPACING IN COMMUNICATIONS MATERIALS AND MODELS

The scope of work required that the assessment team review the communication and behavioral change activities implemented by the Health Communication Partnership (HCP) and the Information and Knowledge for Optimal Health Project (INFO), both under the direction of JHU/CCP.

EXTENT TO WHICH COMMUNICATIONS MATERIALS INCLUDE BIRTHSPACING

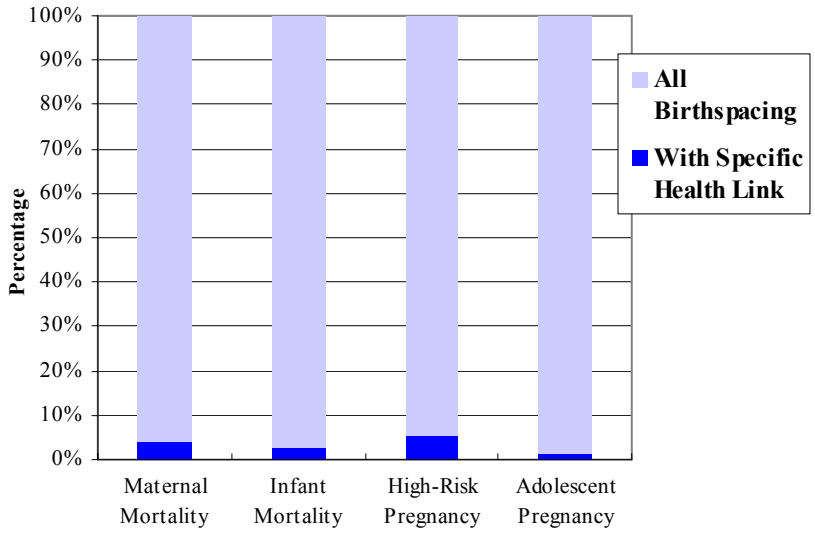
The communications materials database at JHU/CCP was used to conduct a search of the large collection of communications materials assembled over the years from a variety of countries. Conducting a search of 4,353 examples of family planning communications materials, the data based showed that only about 6 percent of the family planning materials assembled were coded as having any birthspacing content (see figure 11).

Figure 11
Portion of Family Planning Communications Materials with Some Birthspacing Subjects
(n = 4,353 items)



When birthspacing was included in communications materials, it was rarely associated with specific health risks. For example, fewer than 5 percent of the examples of birthspacing in communications materials were linked to maternal mortality, infant mortality, high-risk pregnancies, or adolescent pregnancy.

Figure 12
Portion of Communications Materials Associated With Birthspacing Linked to Specific Health Subjects
(n = 801 items)



REFLECTION OF RESEARCH FINDINGS IN COMMUNICATIONS MATERIALS

INFO has produced recent materials that reflect recent research findings relating longer birth intervals to health improvements, including the following:

- Population Reports, *Birthspacing: Three to Five Saves Lives,* in English, Spanish, Portuguese, Arabic (translated by the CATALYST Consortium) and Bahasa Indonesian (translated by the Sustaining Technical Achievement in Reproductive Health [STARH] program). This document has become a widely available reference for the relationship between longer birth intervals and potential health impacts. [9]

- Two radio spots on birthspacing currently are being broadcast in South Africa, Namibia, Nigeria, Uganda, and Zambia and are soon to be evaluated. One of them addresses the advantages of spacing births (see below) and the other addresses family (mother-in-law) concerns about spacing.

[9]English: 106,602 copies distributed via mass mail, and 6,013 copies sent as specific requests
French: 17,664 copies distributed via mass mail, and 611 copies sent as specific requests
Spanish: 37,476 copies distributed via mass mail, and 993 copies sent as specific requests
In addition, Indonesian and Arabic copies were distributed by the respective translators.

RADIO SPOT ON THE ADVANTAGES OF SPACING BIRTHS

ANNOUNCER: This is Your Family Health.

WOMAN: Our baby is 6 months old and you say it is better for my husband and me to wait to have another child, but I don't understand it.

HEALTH WORKER: Let me explain. We health workers know that when couples wait at least two years between babies, the newborn is more likely to survive and be healthy. Your previous young child is also more likely to survive and be healthy. Now we know that waiting longer than two years is even better for the next baby and the mother.

WOMAN: How do you know?

HEALTH WORKER: Medical studies. They show that children born three to five years after a previous child are more than twice as likely to survive as children born before two years have passed.

WOMAN: Is that right?

HEALTH WORKER: Oh, yes, indeed, and waiting helps the mother to avoid anemia. If she waits at least two years she is twice as likely herself to survive childbirth than if her next baby is born just a year or so after the previous child.

WOMAN: I did not know this.

HEALTH WORKER: There are many advantages to waiting.

ANNOUNCER: Visit your local clinic for family planning advice. This is Your Family Health.

HEALTH COMMUNICATION PARTNERSHIP (HCP)

Older JHU/CCP (HCP) national projects/programs with the concept of birthspacing for health reasons have been evaluated. They include the following.

In **Nepal**, the Radio Communication Project (RCP) has nationally broadcast 52 radio episodes a year, which include messages on birthspacing "for the sake of your and your family's health." In an evaluation survey, data showed that 81 percent of women listening to the RCP, compared with 33 percent of women not exposed to the RCP, were currently using a family planning method.[10]

In **Bangladesh**, an evaluation of a national BCC and social mobilization program to reduce maternal mortality indicated that female respondents (new mothers, pregnant women, and mothers-in-law) were increasingly aware of the benefits of optimal birth intervals two years after the baseline.[11] The percentage of new mothers who were aware of birth intervals and health increased from 17.4 to 31.8 percent. Mothers-in-law's awareness also increased significantly. Male awareness did not increase (see table 6 on the following page).

[10] JHU/CCP data

[11] Bangladesh Center for Communication Programs, *Evaluation of Behavior Change Communication and Social Mobilization Program Plan Supporting National Program for Reducing Maternal Mortality,* Dhaka, June 2003.

Table 6
Changes in Birth Interval Awareness, Bangladesh
(in percentages)

	Baseline Survey 2000				Postevaluation Survey 2002			
Birth Interval	**Male**	**New Mother**	**Pregnant Woman**	**Mother-in-Law**	**Male**	**New Mother**	**Pregnant Woman**	**Mother-in-Law**
1 to 2 Years	11.2	7.2	6.7	10.2	25.3	7.1	9.0	7.8
3 to 4 Years	43.8	17.4	27.9	33.3	34.3	31.8	31.3	40.5
5 Years or More	45.0	75.3	65.3	56.4	40.0	61.3	59.8	47.8

A **Nicaraguan** program, "Together We Decide When," begun in 1997, was the first national campaign focusing on reproductive health for Nicaraguan youth. The objective of the campaign was "to reduce unwanted adolescent pregnancies by increasing knowledge about reproductive health and promoting child spacing and postponing the first sexual encounter." Types of action taken by men and women, aged 15–24, exposed to the campaign were talking, preventing pregnancy, postponing union, abstaining from sex, spacing children, and starting family planning, according to a module included in the 1998 DHS. Ten percent of women and 5 percent of men were reported to have spaced children, and 4 percent of both men and women started family planning as a result of the campaign.[12]

In **Senegal** and **other Muslim countries**, BCC has highlighted the support of Islam for birthspacing. For example, a guide produced some time ago for religious leaders quotes the Koran as saying there should be 30 months between conception and delivery.

In **Jordan**, JHU/CCP implemented two national campaigns that included birthspacing: one for men in 1997, and one for youth in 2000–2001. The male campaign, "Together for a Happy Family," promoted men's involvement with their wives in making informed family planning decisions. The youth program, "We Plan for Our Future," sought to empower youth with family planning and life planning information and skills and to increase the successful use of modern contraceptives upon the birth of the first child. In addition to disseminating the idea that modern methods are acceptable and safe, the communications interventions under the youth strategy were to include messages on the risks of unwanted pregnancies for couples relying exclusively on traditional methods.[13] An additional program to reach youth, a perimarital reproductive health effort, is targeted to those about to get married or who are newly married.

Although other activities and factors certainly contributed to this improvement, it is notable that in Jordan, from 1997 to 2001, first year discontinuation rates decreased 6.8 percent (48.8 to 42 percent). As mentioned in section II, during that same period, birth intervals increased by 18 percent.

[12] "Nicaraguan Youth Begin To Play It Safe," *Communication Impact*, November 2001, Number 12, JHU/CCP.
[13] *National Reproductive Health and Life Planning, Communication Strategy for Jordanian Youth, 2000–2005.*

A valuable tool, employed by JHU/HCP to assist national programs in understanding the national demand for birthspacing, has been market segmentation and niche analysis. In **Jordan** in 2002, JHU/CCP began "Demand Generation Through Life Stage and Service Marketing Campaigns" to market services in the public and NGO sectors to cross-cutting consumer groups at various stages of their reproductive lives—youth, young engaged couples, young married couples, and older married couples.

In **Ghana**, under the theme, "It's your life. It's your choice," JHU/CCP worked within public and private sector institutions to increase family planning usage at three life stages:

- **"Not Ready":** "Single unmarried men and women are often not ready for children."

- **"Spacing":** "Young couples often want to plan their children and not have too many children too soon."

- **"No More":** Married couples often decide they are finished having children so they can adequately care for the ones they already have."

A similar approach in 2001 in **Egypt**[14] segmented the family planning market into distinct groups defined by their reproductive life stage and socioeconomic status. Working with DHS data, JHU was able to demonstrate the

- size of the market with unmet need for spacing and

- socioeconomic status, parity, and geographic region of those with an unmet need.

In 2001, 3.6 percent of Egyptian married women of reproductive age, totaling 382,165 women, had an unmet need for spacing. Their median age was 25 years, average parity was 1.6 children, 36 percent were of low socioeconomic status, 43 percent had no education and 68 percent were rural. With such an analysis, national programs are able to develop and target BCC most effectively. There was no evidence that such an analysis of the birthspacing market had been undertaken in the five programs visited by the review team.

[14] Carol Underwood, Fatma El-Zanaty, and Ron Hess, *Market Segmentation: Niche Analysis for Promotion of Family Planning Services and Products,* JHU/CCP, Egypt, 2001.

V. CONCLUSIONS AND RECOMMENDATIONS

POLICIES AND GUIDELINES

Conclusions

Although policies in most countries mention birthspacing, the vast majority do not clearly link birthspacing and the timing of pregnancies with mortality or morbidity reduction. The policies and guidelines, when present, do not normally provide specific guidance about how timing pregnancies can reduce specific health risks. Similarly, even when a recommended birth interval (usually two years) is mentioned, there often is variance in practice or recommendations concerning birth intervals within a country, producing the possibility of inconsistencies in service delivery or messages to clients.

> *I know that birth intervals are linked to maternal and child health, including mortality, but programs for reducing mortality are the responsibility of another department.*
>
> Head of area family planning services, India 2004

In most countries, the policy environment positions birthspacing as an element of family planning programs and not as a serious health intervention that can help reduce maternal or child mortality. In policy and guidelines, birthspacing is often more frequently linked to household harmony or the quality of family life than to health issues. Service delivery practices in the majority of countries assume that birthspacing counseling and services occur in the normal conduct of family planning services; however, when examined, the guidelines, protocols, and provider support mechanisms for specific birthspacing services are often weak or nonexistent, particularly for young, low parity women. Frequently, guidelines provide general rationales for birthspacing and do not cover the specific health risks associated with birth intervals.

Interestingly, in some countries where there are sensitivities around family planning, birthspacing is used at the policy and guidelines level as a synonym for any family planning service. In these contexts, the relationship of birthspacing to mortality or morbidity reduction often seems to be particularly vague.

Recommendations

National polices should acknowledge the significant role of birthspacing in mortality reduction strategies.

If the potential contribution that birthspacing can make to mortality reduction is to be realized, policies need to clearly recognize the role of longer birth intervals to mortality reduction. Future policy discussion efforts should include an effort to have birthspacing services identified as a legitimate intervention for reducing both maternal and child mortality. For example, birthspacing service delivery should be included within child survival policies along with such standard child mortality–reducing interventions as immunizations, treatment of acute respiratory infections, or malaria control.

Policies and service delivery guidelines should focus birthspacing efforts on young, low parity women.

Policies should also clearly acknowledge which segments of the population (young, under age 29, low parity women) can most benefit from birthspacing. Zero parity women particularly need to be identified in policies and service delivery guidelines as having some preexisting demand for birthspacing and as being eligible for quality services that require the attention of service providers and program managers.

Birthspacing efforts need a program measurement indicator that senior decision-makers and program mangers regularly monitor.

Birth intervals should be added to the list of indicators used to measure program and health sector performance over time. When choosing a specific indicator for birth intervals, consideration should be given to the possibility of using age-specific (e.g., ages 15–19 and 20–24) birth intervals as the indicator of choice.

Policies and protocols for service delivery should accommodate the needs of at-risk clients.

Policies and service delivery guidelines are largely silent on the issues of intimate partner violence and women who are subjected to the risk of pregnancy through coercion. Younger, often low parity, women appear to be affected by such issues more frequently than do older, higher parity women. Where such circumstances exist (and these issues seem to be underestimated), policies and protocols for birthspacing need to provide some guidance for services. That guidance should include realistic options so that such at-risk women have access to contraceptive methods that are not partner compliant–dependent.

COMMUNICATIONS AND BIRTHSPACING

Conclusions

The two major projects (HCP and INFO) reviewed incorporated BCC messages on longer birth intervals and the risks of too short intervals in all of the country materials supplied to the team. Evaluations of those efforts indicate that such messages lead to behavior change. Similarly, there are examples of communications efforts that do include effective birthspacing messages; however, a search of all family planning communications materials available centrally in the JHU/CCP database indicates that birthspacing is a topic that has been relatively rarely included in communications materials. Communications materials typically do not relate birth intervals or the timing of pregnancies with specific health risks. The review of communications materials, therefore, also indicates that, although some good examples exist, coverage of birthspacing topics and the relationship of birth intervals to specific health risks in general have been weak in global communications efforts for family planning.

Recommendations

There continue to be many barriers to successful communications and outreach. First, it is essential that demand and supply dimensions be kept in balance. Messages on spacing births through the use of contraception will be, at a minimum, frustrating to women if there are no contraceptives for spacing in the local clinic. Countries and donors must

assure supplies if demand generation is to be effective. In countries where women lack knowledge and/or understanding of modern methods or where fear of side effects is significant, BCC needs to provide information and deal with such issues as side effects and myths as well as identify the relationship between intervals and health. Jordan is a good example of a country where the national program included activities for both demand and supply and where behavior change activities included information and education on modern contraception as well as messages on spacing.

Communications efforts should educate about the specific health risks associated with the timing of pregnancies.

Greater effort is needed in future communications efforts to incorporate messages about the specific health risks that can be minimized through longer birth intervals. Additional counseling and client–provider interaction tools are needed for use with young, low parity women. Additional information materials on birthspacing for the zero parity, recently married woman are needed. Given the relative weakness of birthspacing in communications efforts in some countries historically, consideration should be given to the creation of a birthspacing initiative within globally and bilaterally funded communications programs for reproductive health.

Additional communications efforts are needed to address the barriers women face in exercising choice for the timing of pregnancies.

BCC activities should be increased that address the barriers women face (lack of knowledge, fear of side effects, provider bias) in implementing their birthspacing desires. Similarly, communications and program efforts need to develop culturally appropriate strategies for reaching men and other family members (such as mothers-n-law) about how healthy birth intervals can reduce health risks.

TRAINING AND BIRTHSPACING

Conclusions

As was the case with the assessment of communications materials, the review of training materials indicated that while some good examples of birthspacing content in the materials exist, birthspacing is missing or inadequately covered in substantial numbers of training examples. Furthermore, the finding that the training protocols examined are largely silent on the issue of counseling young, zero parity women illustrates the lack of capacity within the community of service providers to respond to the needs of women who may be interested in postponing a first birth.

Recommendation

Strengthen training to respond to the birthspacing needs of young, low parity women, particularly for counseling.

Donors (such as USAID, the United Nations Population Fund [UNFPA], WHO, and the United Nations Children's Fund [UNICEF]) should develop standard protocols for training providers to respond to the needs of young, low parity women, including the recently married, zero parity woman. Additionally, USAID could include a specific

birthspacing training component in its relevant global projects to develop model training protocols for birthspacing. Such training protocols should be oriented to service providers, supervisors of service providers, and service delivery program mangers.

STATUS OF RESEARCH

Conclusions

Available survey data (such as those produced by the DHS) provide valuable information relevant to the design and monitoring of birthspacing services. Unfortunately, much of that data remains underused for program planning or monitoring purposes when it comes to birthspacing. This is sometimes true for general family planning as well, particularly in the application of unmet need information.

> *To get health professionals and senior officials to treat birthspacing as a serious intervention to reduce mortality, national experts will need to analyze country data to determine the specific health benefits that are possible in this country from birthspacing.*
>
> Health sector analyst, Uganda, 2004

Available research on specific birthspacing issues among younger, lower parity women is limited. Additional research will be needed to better understand the dynamics of decision-making surrounding the timing of pregnancies among younger women. Availability of data is particularly scarce for zero parity women and the factors that affect their decisions to use contraceptives or not.

Recommendation

Support new research on the factors affecting decisions for the timing of pregnancies and access to birthspacing services.

Additional research is needed to explore the barriers that young, low parity (particularly recently married, zero parity) women face in deciding to postpone or time pregnancies. Research is also needed that explores the community of service providers and program managers in order to better understand the factors that influence their ability to offer birthspacing services to younger, lower parity women.

PROGRAM GAPS

Conclusions

From all the information gathered and the independent assessments of programs, training materials and communications efforts, birthspacing interventions in the countries examined are often a weak part of family planning programs. It is commonly assumed that birthspacing efforts are ongoing whenever a family planning program exists; however, the specific health benefits of longer birth intervals are usually not a program emphasis within family planning service delivery organizations. The fact that birthspacing services are not typically a part of health interventions being pursued in countries by those offices charged with reducing maternal or child mortality illustrates

that there are significant programmatic gaps between contraceptive service delivery and the contribution longer birth intervals could make to improvements in maternal and child health. As long as these gaps exist, the potential contribution of longer birth intervals to mortality and morbidity reduction is unlikely to be fully realized.

Specific Recommendations

Several efforts could be taken to enhance birthspacing services within programs at the national and subnational levels.

A commonly used (cross-country) sector-level indicator for the status of birthspacing is needed.

Age-specific birth intervals should be used as a standard program indicator or for measuring progress against Strategic Objectives in both population and maternal/child health sectors.

Program progress indicators need to distinguish between relevant segments of beneficiary populations.

Mean age-specific birth intervals (for 15–19, 20–24 and 25–29 age cohorts) should be included as performance indicators for global and bilateral family planning projects and health projects with an objective of reducing maternal or child mortality.

Standard analyses and reporting on national health surveys should include more detailed birthspacing information.

DHS operational and reporting definitions related to demand and need for birthspacing should be modified to a variety of longer birth interval desires (the current standard normally defines demand for spacing as wanting to space at least 12 months) and reporting definitions standards.

A more secure supply of short-term contraceptives, particularly for injectable contraceptives, is critical.

Since several countries identified contraceptive supply shortages as an issue affecting the ability of a woman to space births, efforts with donors and host country governments should be increased to ensure the supply of short-term contraceptive methods. Depo-Provera was identified repeatedly by respondents as being both in demand for birthspacing and in short supply. The supply situation for Depo-Provera should be examined to see if there is any supply issue specific to this method.

Specific needs of at-risk women should be better accommodated in service delivery programs.

In countries where intimate partner violence is a substantial issue, there is a need to place specific emphasis on efforts to ensure that women have contraceptive options that are not partner compliant–dependent. More communications efforts are needed for men to inform them about the health issues for their wives and children that are associated with the timing of pregnancies. Greater efforts are also needed to involve males in healthy birthspacing and informing them how they can contribute to the health and well-being of their families.

The right to know about the health risks associated with the timing of pregnancies should be a guiding principle for all service delivery programs.

Donors and development agencies should advocate for the principle within service delivery programs of women's right to know of the correlation between birth intervals and health risks for women and children. To incorporate this principle meaningfully in many programs will require considerable support and assistance, from policy discussion to training to communications efforts and management priorities.

VI. KEY ELEMENTS FOR STRONGER BIRTHSPACING SERVICE DELIVERY

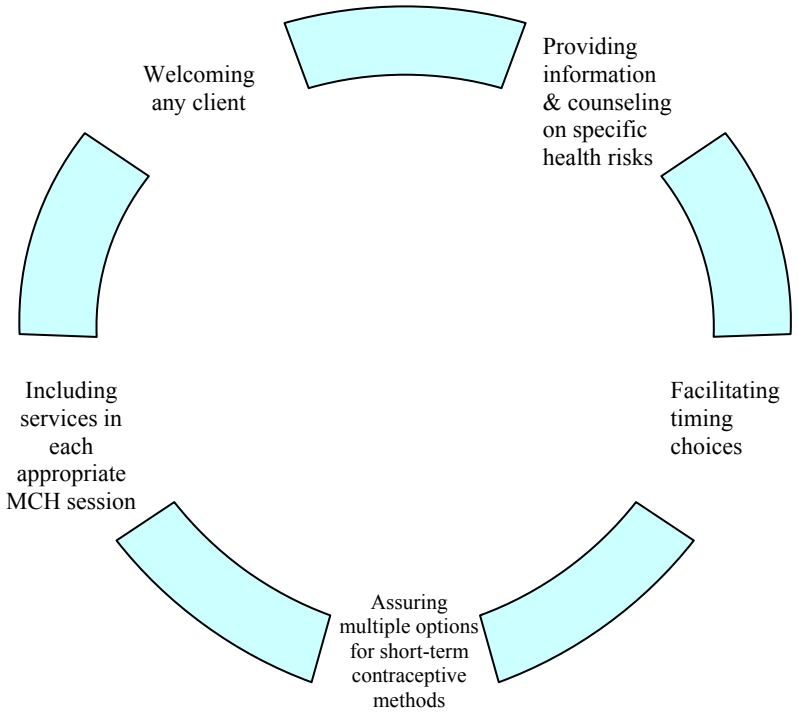
The essential ingredients for successful contraceptive service delivery are fairly well known. To strengthen the contributions of birthspacing to maternal and child health, however, these proven elements of successful service delivery need to be reoriented to improved health outcomes and integrated within primary health care services.

Stronger birthspacing efforts need to be securely based on national maternal and child health policies and viewed as a means for achieving mortality reduction objectives. Birthspacing needs to be an active, vibrant part of the services regularly offered at facilities to protect the health of women and children. Senior policymakers and managers of services need to commit to making birthspacing an integrated part of maternal and child health services. Programs should be oriented to those who can most benefit from better pregnancy intervals (i.e., those who are younger and with fewer children, including those who have not yet had a child). Communication efforts need to regularly inform communities and couples about the health benefits of birthspacing and the specific health risks to both women and children associated with short birth intervals. Reliable availability of short-term contraceptives is essential. Program managers and senior decision-makers should regularly review birthspacing indicators to encourage progress in birth intervals (see figure 13).

Figure 13
Program Environment for Stronger Birthspacing Services

As with all service delivery efforts, quality of care is an essential ingredient for success. Many quality issues exist for effective birthspacing service delivery; however, there are some factors that seem particularly relevant for maximizing women's access and use of birthspacing services (see figure 14).

Figure 14
Circle of Quality for Birthspacing Services



WELCOMING ALL POTENTIAL CLIENTS

Cultural stereotypes and provider bias are widespread about which clients are interested in birthspacing or when childbirth should begin. Informed clients should take the lead in their choices about the timing of pregnancies and births. Quality service delivery should respond to any clients with an interest in implementing their choices about the timing of pregnancies. Anyone with an interest in birthspacing should be welcome.

PROVIDING SUPPORTING INFORMATION AND COUNSELING

Accurate information about the specific health risks associated with the timing of a first or subsequent pregnancy is essential for women to make informed reproductive choices. Indeed, women have a right to know about relative risks associated with the timing of pregnancies and sound client–provider interaction protocols are needed to facilitate appropriate counseling for choices surrounding the spacing of births.

FACILITATING CLIENT CHOICES

The counseling process needs to be informative and services need to be offered in a manner that allows the client full freedom to choose when to have a child. Services need to be offered to women on demand and without judgment on the question of when childbearing should begin. For example, newly married women who desire to delay their first pregnancy should have their wishes facilitated in the service delivery setting without comment or judgment.

ASSURING A VARIETY OF SHORT-TERM METHOD OPTIONS

Clients need to have several short-term methods from which to choose and the service provider should counsel on the relative advantages of each.

INCLUDING BIRTHSPACING SERVICES IN APPROPRIATE MATERNAL AND CHILD HEALTH SESSIONS

Access to birthspacing services will be increased if birthspacing services are offered to clients at multiple maternal/child service delivery events. For example, prenatal visits and regularly scheduled immunizations of well babies are excellent opportunities to provide birthspacing information and services to clients.

APPENDICES

CASE STUDY

APPENDIX A

SCOPE OF WORK
(from USAID)

USAID
BIRTHSPACING PROGRAMMATIC REVIEW
SCOPE OF WORK

Rev. 01-20-04

I. SUMMARY

USAID (Bureau for Global Health, Office of Population and Reproductive Health) seeks the services of a Contractor (POPTECH) to: (1) conduct a review of birthspacing activities in USAID-assisted family planning/reproductive health and child and maternal health programs; and (2) make recommendations to improve birthspacing program strategies.

II. BACKGROUND/RATIONALE

A) New evidence

New research, more methodologically rigorous than previous studies, underscores the critical role that child spacing plays in maternal and child health and nutrition. Important new findings include the following:

- Birth intervals of 24 months are still associated with a 26% increased risk of death for newborns, compared to 36 month intervals.[i]
- Extremely short birth intervals – less than 15 months -- are associated with a 150% increased risk of maternal death, as well as related health complications.[ii]
- Birth intervals of 20 months or less are associated with increased risk of preterm delivery, fetal death, low birth weight, early neonatal death and low Apgar score.[iii]
- Even after taking breastfeeding into account, children born at less than three year intervals are at greater risk of dying, compared to children born at 3-5 year intervals.[iv]

B) Need for new strategies and programs

Families should be informed of the risks of too closely spaced births, as well as the health, nutritional and other benefits of longer intervals, to help ensure healthy birth outcomes. Many family planning programs, however, focus principally on contraceptive methods and side effects, and fail to include information on the benefits/risks of long and too short intervals. Birth interval data indicate that new strategies and program models are needed to reduce the relatively large percentage of too closely spaced births in many countries. Trends/issues are as follows:

- The majority of non-first births in developing countries occur after too short an interval. In 55 developing countries, 57% of women have spaced non-first births shorter than three years. And 26% have spaced births less than two years apart. In at least five Latin American countries, approximately 95-97% of adolescent girls, ages 15-19, have birth intervals of less than three years. [v]

- In many countries, the percentage of short birth intervals is static or increasing. In many developing countries, the percentage of married women of reproductive age experiencing short birth intervals has declined minimally, or not at all. For example, over the past five to ten years, in Burkina Faso, Madagascar, Niger, Tanzania, Uganda, Zambia, Nepal, Philippines, Bolivia, and Yemen, there has been a reduction of only 1-2% percent in women reporting birth intervals under three years. *In India, Mali and Haiti, the percentage reporting intervals under three years has increased.*[vi]

- Women want longer birth intervals, but are not achieving them. Global data show that only 2-3% of post-partum women report wanting another birth within two years, yet only 40% are using family planning.[vii] If women could achieve the birth intervals they want, child mortality would decline. For example, in Kenya, under-five mortality would drop by 17%.

- Absence of service delivery guidelines, policies and protocols. Currently, there are few norms, standard protocols, training materials or guidelines for birthspacing counseling in developing countries and limited training curricula. USAID-sponsored focus groups conducted in five countries (Bolivia, Peru, India, Pakistan and Egypt) indicate that clients, providers, and NGOs (which could potentially play an educational and outreach role) often do not understand the relationship between birthspacing and child and maternal survival and nutritional status. Providers indicated that they do not discuss the benefits and risks of longer and short birth intervals due to the absence of standard guidance and protocols. Specifically, they understand birth spacing as generally good for health, but lack information on the mortality/morbidity/nutritional risks of short intervals for both mother and child. In addition, it appears that policy makers and program managers have not received adequate information on the potential economic, fertility, nutrition and health benefits of birthspacing.

If women were able to achieve the intervals they wanted, the potential positive effects on maternal, newborn and infant mortality would be considerable. These issues suggest the need for improvements in birthspacing program strategies.

C) Role/support of USAID and its partners

The Bureau for Global Health, Office of Population and Reproductive Health expects to meet in the spring of 2004 with WHO, DFID, UNICEF and other donors and partners concerning global leadership and field program activities to strengthen birthspacing programs in developing countries.

In preparing for this event, USAID, in collaboration with WHO and UNICEF, is sponsoring a systematic birthspacing literature review. The purpose of the literature review is to investigate the evidence-base on the relationship between interpregnancy/birth intervals and health and nutritional outcomes for newborns, infants, children and women. The review will be completed in the spring of 2004.

The Office of Population and Reproductive Health also wants to undertake a programmatic review of birthspacing education, counseling, outreach and related components (e.g., policy; research; nutrition; monitoring and evaluation) in family planning/reproductive health/and child and maternal health programs to document best

practices and identify gaps and opportunities for improvements. It is hoped that the programmatic review will be completed at approximately the same time as the literature review so that the findings from both studies can be presented at the 2004 meeting of USAID and its partners and other donors.

III. OBJECTIVE

Purpose of the Review

The Office of Population and Reproductive Health wishes to review and document birthspacing education, counseling, and related components in family planning/reproductive health/and child and maternal health programs. This review will address two broad questions:

- How effectively are programs educating families, providers and policymakers about birthspacing as a maternal and child health intervention?
- What program improvements are needed?

Specifically, the review will:

- document current birthspacing services, counseling, education, outreach and other activities in select countries, i.e., the strategies and approaches used to:
  (a) educate women, men, providers and policymakers about the health, nutritional and other benefits of optimal birthspacing; and
  (b) deliver the appropriate services that help women (including zero parity women) achieve the birth intervals they want;

- review birthspacing training and educational materials, including communication/behavioral change materials and programs, job aids, tools and community outreach materials;

- identify gaps in programming;

- make recommendations to improve birthspacing counseling, outreach, client and provider interaction, behavior change communication, research, monitoring and evaluation and policy.

IV. METHODOLOGY

A) Role of the Office of Population and Reproductive Health

The Office of Population and Reproductive Health plans to coordinate with WHO and UNICEF to sponsor an international meeting in 2004 on birthspacing in developing countries. In preparation for this meeting, USAID will fund literature and programmatic reviews on birthspacing, and will coordinate with relevant USAID Cooperating Agencies.

B) Approach to the Birthspacing Programmatic Review

The Birthspacing Programmatic Review will be carried out as follows:

POPTECH will coordinate all aspects of the Review and provide the Team Leader and a second team member. USAID will provide 1-2 non-direct hire (NDH) team members, to conduct site visits and work with the POPTECH team. The Team Leader will review the country reports of the Cooperating Agencies (CAs) involved, and supervise the preparation of one report that incorporates findings, conclusions and recommendations from the CA reports, the POPTECH team CA interviews and the country site visits.

Service delivery CAs, consisting of PRIME, CATALYST, Advance Africa, JHPIEGO and Engenderhealth, will gather information on birthspacing programming in field-supported programs. JHPIEGO will assist with the review of relevant CA training, counseling and educational materials, job aids and national protocols. They will provide short country reports.

POPTECH will support the visits of its consultants to the field. CA and indirect-hire resources will support the other components, including travel-related costs by NDH staff.

C) Statement of Work

Team Site Visits: Two consultants (one of whom is the Team Leader) and possibly 1-2 USAID NDH staff will constitute the team conducting the field visits. The team will interview Ministries of Health, CAs, PVOs/NGOs, and private sector groups, to answer the questions included in Section V, and will seek to identify tools and approaches used for counseling and educational outreach, as well as programming gaps and opportunities. The team will also review the most recent DHS surveys for the site-visit countries to understand birth spacing intervals and trends, as well as key documents, studies and reports on birthspacing to become familiar with the latest research findings.

The team will begin their work in Washington, D.C., with a team planning meeting, interviews with Global Health Bureau and select CA staff and review of the most recent research studies. The team will prepare a proposed outline of their report and present it to USAID prior to departure.

The criteria for selecting countries for site visits are:

- countries where use of spacing methods is low and/or fertility/infant/maternal mortality is high (India; Pakistan; Uganda; Nigeria);
- countries which are taking positive steps to address birthspacing programmatically (Guatemala; Egypt; Bolivia);
- countries where adolescent sub-groups have extremely high percentages of too closely spaced births (Peru; most LAC countries).

Based on these criteria, the team would be divided into two. Assuming mission concurrence, one team would conduct site visits in **Uganda, Nigeria, Pakistan and India** (one team member could go to Nigeria, one could travel to Uganda and they could then meet in Pakistan/India). The other team would conduct site visits in **Guatemala, Peru and Bolivia.**

CA Country Reports: PRIME, CATALYST, Advance Africa, JHPIEGO and EngenderHealth staff will work together, and with each CA's respective country staff, to gather information on birthspacing programming at the country level. Each will use a standard questionnaire, developed as part of this review, to interview key informants, partners and other donors. (If more than one CA works in a country, only one CA will be asked to answer the questionnaire.) The draft questions are included in Section V. We anticipate a 3-5 page report from each country.

The criteria for country selection for the country reports are:

- countries where the percentage of birth intervals less than 3 years apart has not declined, declined minimally, or has increased, in the past five to ten years (Table 1);
- countries having relatively high infant/maternal mortality rates, and large populations (Ethiopia; Pakistan);
- countries/regions where demand for spacing methods among zero parity women is relatively (and surprisingly) high (Uttar Pradesh, India; Bangladesh; Mali; Nicaragua; and Peru) [viii]

These countries, and the CA which will be responsible for data collection from these countries, are listed below.

PRIME staff will gather information from the following countries: Ghana, Malawi, Jordan, Kenya, Tanzania, Rwanda, Zambia, Mali, Uganda, Haiti and Nigeria.

CATALYST staff will gather information from the following countries: Guatemala, Peru, Bolivia, Egypt, Pakistan, Yemen, Nepal, Dominican Republic, Bangladesh, Nicaragua, Philippines and India.

Advance Africa staff will gather information from the following countries: Madagascar, Mozambique, Angola, DRC, Senegal, and Ethiopia.

Table 1: Trends in Birth Intervals:
Percentage of Married Women of Reproductive Age Reporting Birth Intervals Under 3 Years, Multiple Surveys, 1986-2001[ix]

Country	Number of Years between DHS surveys	% Reduction Between First and Last Survey
Madagascar	5	2
Malawi	8	4
Mali	8	Percentage has increased
Nigeria	9	4
Senegal	11	7
Tanzania	4	1
Uganda	12	1
Zambia	4	<1
India	6	Percentage has increased
Nepal	5	<1
Philippines	5	1
Bolivia	9	2
Dominican Republic	10	6
Guatemala	11	1
Haiti	6	Percentage has increased
Jordan	7	6
Yemen	6	2

Review of Training Materials A JHPIEGO consultant will review relevant CA training, counseling and educational materials, job aids and national protocols. This will include relevant training and other materials from Pathfinder, INTRAH, EngenderHealth, Georgetown University, FHI, PATH, IPPF, and JHPIEGO (including MNH).

The purpose of reviewing training and counseling materials is to identify: (a) state-of-the-art materials, as well as gaps and opportunities for improvements; and (b) the countries in which the birthspacing educational materials have been used in implementing programs. The report should be approximately 5-10 pages in length.

Review of Communication and Behavioral Change Activities The POPTECH team will also review communication and behavioral change activities implemented by the Health Communication Partnership (HCP) and Information and Knowledge for Optimal Health (INFO). The purpose is to examine the extent to which these activities, and predecessor activities, are currently preparing, and have in the past prepared, communication/behavioral change materials and implemented programs that educate families about the benefits of longer birth intervals and the risk of too short intervals.

D) Preparatory Meetings

To facilitate communication and coordination, and to ensure that the CAs complete their work by mid-January 2004, two preparatory meetings are planned. The meetings will be organized and sponsored by USAID, and POPTECH will provide a venue and record the outcomes.

Initial meeting (12-11-03): The meeting will bring together USAID CTOs, CA project directors, and POPTECH staff to discuss the purpose of the Review, agree on the questions to be addressed (standard questionnaire), assign roles and responsibilities, and plan a coordinated approach for preparing country reports.

Orientation meeting (01-20 & 21-04): The POPTECH Team will meet with key CA representatives and USAID staff to:

- discuss the findings, conclusions and recommendations resulting from the CA country reports(day one); and

- receive guidance on the assignment, including coordination of the country visits (day two).

POPTECH Team meetings: The Team will assemble in Washington D.C to participate in a Team Planning Meeting at the time of the Initial meeting in December and during the week of the Orientation meeting in January 2004. It will also conduct interviews in January with Global Health Bureau staff, present a proposed outline of the report to USAID, and make final preparations for site visits.

E) Background documents

USAID will provide the following documentation: ***(to be completed)***

V. QUESTIONS THE REPORT WILL ANSWER

A) CA country and field visit reports

For each site-visit country **OR** CA country report:

- Background Information: Please use DHS and other data to provide background information about the country. Include data on: current spacing intervals (especially in the 15-24 age groups); women's preferred birth intervals if known; unmet need for spacing methods (including for zero parity women); FP one-year continuation rates; CPR for zero, one and two parity women; exclusive breastfeeding/LAM trends; and recent spacing and newborn/infant/child and maternal mortality and nutrition trends.

Questions:

- To what extent do written policies, norms, standards, and/or training materials provide guidance on counseling families about the relationship between short intervals and mortality/morbidity risks for mother and child, and about optimal birth intervals and health and nutritional benefits? If written standards exist, what guidance do they contain?

- To what extent are the relevant CAs, PVOs/NGOs and Ministries of Health implementing programs (including mass media, behavioral change and community outreach programs) to educate women and men (including zero parity women and women in the post-partum/antenatal period) and/or providers about the risks of too short intervals and the health, nutritional and other benefits of longer birth intervals?

- What appear to be the most important issues (access, quality, gender, knowledge, logistics/commodities, economic, other) that affect women's ability to achieve the birth intervals they prefer? Is there any relevant, country-specific research on this topic?

- Is research available that indicates that women and men understand the concept of "planning and spacing births"? Or, do they understand the words "family planning" to mean the limiting of births after desired family size has been achieved?

- Are opinion leaders aware of the relationship between birth intervals and child and maternal survival? Are they aware of zero parity women's unmet need for spacing methods?

- How does the current contraceptive method mix support women's birthspacing preferences? Is emergency contraception available?

- For each country, is the team able to identify any evidence-based interventions/program models that have: (a) improved FP one-year continuation rates; (b) helped women (including zero parity women) achieve the intervals/postponed births they desire; and/or (c) effectively counseled women in the post-partum period about the risks of too short intervals and the benefits of longer intervals?

- For each country, are any policy changes needed (or have they been made recently) to facilitate and support improved birthspacing counseling, education, outreach and other activities?

- Each DHS survey usually contains a wealth of birthspacing data. How are CAs, partners, and USAID using these data for monitoring and program improvements?

B) Training Questions

This portion will largely be a desk review of current CA training materials and other tools and will answer the following questions:

- To what extent do training materials, protocols, client-provider interaction guidance or other educational and outreach tools/strategies contain guidance that can be used by providers, supervisors and managers to educate clients about the health and other benefits of spacing births 3-5 years, and the risks for mother and child of short intervals?

- Does the material reflect the latest research findings on birthspacing?

- Is the training approach realistic?

- Does this material provide a technically sound approach for translating the technical information into practice? Is there a better way?

- Please prepare a table that documents and describes these materials. (All team members should contribute to this section.)

C) Questions the Final Report will Answer

After reviewing the CA country reports, the training report and site-visit country reports, the POPTECH team will prepare one consolidated report that answers the following questions:

- In developing countries, are written policies, guidelines, standards and training materials on birthspacing counseling available to guide FP/MCH programs? What are the best examples of such materials? In what countries are such materials lacking?

- To what extent have USAID-supported communication and behavioral change programs incorporated educational messages on the health and other advantages of longer birth intervals, and the risks of too short intervals?

- Is research available that indicates that women and men understand the concept of “planning and spacing births”? Or, do they understand the words “family planning” to mean the limiting of births after desired family size has been achieved?

- What types of policies, guidelines, protocols, tools and behavioral change/communication programs need to be developed?

- What do you see as the major challenges to implement improvements in counseling, community educational outreach and other strategies?

- Are there other gaps in programming?

- What other priority steps should USAID and other donors and Ministries of Health take to guide improvements in birthspacing programming?

VI. QUALIFICATIONS

Description of the qualifications required for the Team Leader and second team member:

Team Leader: Knowledge/understanding of birth spacing research; ideally, participation in CATALYST birthspacing champions meetings; understanding of and experience with family planning and reproductive health service delivery; developing country experience; excellent writing and inter-personal skills; demonstrated ability to lead a team and produce a product by deadline.

Team Member: Understanding of and experience with family planning and reproductive health service delivery; developing country experience; excellent writing and inter-personal skills; demonstrated ability to work collaboratively with a team and produce a product by deadline.

VII. PROPOSED LEVEL OF EFFORT `

It is estimated that up to seven weeks of effort will be required for each of the POPTECH consultants, and possibly an additional week for the team leader. The consultants will perform some of the work at home prior to the team's arrival in Washington, D.C. and after the country site visits are completed. The consultants are authorized to work a six-day week when in the field.

VIII. DELIVERABLES

A) Report

After completing the fieldwork, the team will prepare a draft report that incorporates the views expressed by USAID and its partners, CA country reports, the training report, and the information gathered during the site visits. The report will address the key questions cited above and include a stand alone executive summary that provides key evidence-based findings, conclusions and recommendations. The final report will be about 25 to 30 pages, plus attachments. One of the attachments will be a "Case Study on Bolivia." The report will be external and edited by POPTECH.

B) Debriefings

The team will conduct debriefings with USAID and the CAs in Washington, D.C. for the purpose of sharing the key findings and recommendations.

IX. FUNDING, SCHEDULING AND LOGISTICS

POPTECH will provide all funding and logistical support for preparation of the report and site visits. The Training Consultant, and funding, will be provided by JHPIEGO. The Team Leader will consult and communicate with the five CAs (PRIME, JHPIEGO, CATALYST, EngenderHealth and Advance Africa). He/she will ensure that the findings from all reports are fully incorporated into the final report. The details regarding the selection, scheduling and logistics of the country visits will be finalized during the Initial meeting with the CAs and USAID staff.

[i] Rutstein, Shea, *Effects of Birth Interval on Mortality and Health: Multivariate Cross-Country Analysis*, ORC MACRO, Presentation at USAID, July 2000.

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[iii] Special analysis prepared by A. Conde-Agudelo and presented in: Setty-Venugopal, V. and Upadhyay, U.D. *Birth Spacing: Three to Five Saves Lives*. Population Reports, Series L, No. 13. Baltimore, Johns Hopkins Bloomberg School of Public Health, Population Information Program, Summer 2002.

[iv] Rutstein, Shea, *Effects of Birth Interval on Mortality and Health: Multivariate Cross-Country Analysis*, ORC MACRO, Presentation at USAID, July 2000.

[v] Setty-Venugopal, V. and Upadhyay, U.D. *Birth Spacing: Three to Five Saves Lives*. Population Reports, Series L, No. 13. Baltimore, Johns Hopkins Bloomberg School of Public Health, Population Information Program, Summer 2002.

[vi] Ibid.

[vii] Ross, J. A. and Winfrey , W. Contraceptive use, intention to use, and unmet need during the extended postpartum period. International Family Planning Perspectives 27 (1): 20-27. Mar 2001.

[viii] Jansen, William H., Frick, Dianna, Mason, Rich, The "X" Factor in Birth-Spacers: Age and Parity in Demand and Need for Birth-Spacing in 15 Developing Countries, Paper Presented to the Population Association of America, May 2002.

[ix] Venugopal and Upadhay, p.9.

APPENDIX B

PERSONS CONTACTED

PERSONS CONTACTED

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Arjuma Kumar, Additional Director, Family Welfare

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Baruar Village, Uttar Pradesh
Panchayat Representatives

Paharikalan Village, Uttar Pradesh
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APPENDIX C

COUNTRY DATA COLLECTION INSTRUMENTS

COUNTRY DATA COLLECTION INSTRUMENTS

USAID BIRTHSPACING PROGRAMMATIC REVIEW

Methodology for Collecting and Reporting Country Profile Information

I. Introduction

USAID (Bureau for Global Health, Office of Population and Reproductive Health) has asked selected cooperating agencies (CAs) and POPTECH to help in performing a review of existing birthspacing efforts in service delivery programs in the developing world. The two main objectives of the review are to (1) identify and describe existing birthspacing activities in USAID–assisted family planning/reproductive health and child and maternal health programs, and (2) make recommendations on how to improve birthspacing program efforts or strategies for the future.

II. Country Assessment Reports

USAID has asked PRIME, CATALYST, Advance Africa, and EngenderHealth staff to work together (involving each CA's respective country staff) to gather the information needed to develop a better understanding of the status of birthspacing programming and birthspacing service delivery at the country level. By using a standard set of questions to generate the needed information, comparable information will be available from each country and such comparability will facilitate the identification of patterns that are present cross-country.

Even if more than one CA works in a country, only one CA will be asked to coordinate and be responsible for assembling all the information reported for a given country. A 3–5 page report from each country is anticipated.

III. Two-Tier Approach to Information Gathering for Countries

In the interest of efficiency in time and effort, the method for gathering information for all countries will focus on the work or programs that CAs are directly involved with or knowledgeable about in the countries where they operate. This category of "CA program only" information constitutes Tier 1 and for the countries in Tier 1, the responses of CA staff to the questions contained in the questionnaire are sufficient for the level of information sought. Consequently, the "sample" of respondents to questions for countries in Tier 1 consists of CA staff. The methodology for seeking answers to the country questions is limited to identifying the appropriate CA staff members that are knowledgeable about work in the particular country.

Some countries have been identified for additional information gathering efforts. In these more indepth countries, additional information collection efforts will be undertaken and site visits by the POPTECH team are scheduled. For these Tier 2, indepth countries, additional information, collected from others besides immediate CA staff, is sought and should be collected from other types of respondents. In Tier 2 countries, it is intended to use the questionnaire to collect information from knowledgeable individuals of other organizations, such as ministries of health, nongovernmental organizations (i.e., family planning associations and service delivery groups), and commercial providers of services. Accordingly, Tier 2 indepth countries should have information generated from CA staff and a minimum of two other organizational sources.

Tier 2 countries will also be visited by members of the central assessment team. During these site visits, team members will work with lead CA staff to interview individuals using the questionnaire and to collect additional information. The lead CA identified for the indepth country is expected to facilitate the visit and work of the team in-country.

IV. Sampling Approach for Indepth Countries

Identifying useful sources of information about the status of birthspacing services in-country is dependent upon country circumstances and the networks the CA has in-country. However, the assessment should focus on the specific organizations (Ministry of Health, social security administration, family planning association, faith-based organizations) that are most active in-country. For indepth countries, the intent is to gather sufficient information to allow as complete a representation of the most popular sources of family planning and other reproductive health services as possible. In the most prevalent service delivery networks, a variety of individuals could serve as useful interviewees and could include senior program managers, midlevel managers, and frontline service providers. An example of a possible sample of representative interviewees from a service delivery organization could be one senior program manager or leader, two midlevel managers, and four or five service providers.

V. Country Listing in Each Tier and CA Assignments

The countries in the sample and the CA that will be responsible for data collection from these countries are listed below.

Tier 1: CA Only Countries

- CATALYST: Egypt, Nepal, Bangladesh and Yemen. Principal Contacts: Graciela Salvador-Davila and Elsa Berhane
- EngenderHealth: Jordan and Kenya. Principal Contacts: John Pile and Aparna Jain
- PRIME: Ethiopia, Rwanda, El Salvador, and Paraguay. Principal Contacts: Laurie Parker and Ann Lion-Coleman
- Advance Africa: Mozambique, Zimbabwe, DRC, Senegal, Angola, and the Philippines (through MSH). Principal Contacts: Yousef Draogo, Angela Stonebarger
- JHU/CCP: Nicaragua

Tier 2: Indepth (CA+) Countries

- CATALYST: Guatemala, Peru, Bolivia and Pakistan. Principal Contacts: Graciela Salvador-Davila and Elsa Berhane
- EngenderHealth: India and Nigeria. Principal Contacts: John Pile and Aparna Jain
- Uganda

VI. Information Synthesis and Report Preparation

A point person in the headquarters at each CA should take the lead in assembling the country reports and reviewing the information submitted from countries. Whenever possible, quantification of the aggregated responses from persons or sources of information in-country would be useful. For example, narrative of the findings could have such statements as "two out of three responses to the question were, 'no'."

In countries where multiple persons are interviewed, a table can be used to summarize and aggregate responses to questions. Reporting of the information gathered in any narrative should be grouped by the categories (9) indicated in the question list. If multiple individuals were interviewed, please attach copies of the completed questionnaire for each person interviewed as an appendix to the report. Responses to question 4(c) should be a number; so, in instances where multiple responses are available for a given country, the report narrative can give an average (mean) figure in the text for this variable.

VII. Time Line for Information Gathering and Report Submission

Tier 1 Countries

- CAs send country questions and guidelines to their offices in countries by 1/12/04 (latest date)
- CAs submit completed country reports to POPTECH by 2/13/04.

Tier 2 Countries

- CAs send country questions and guidelines to their offices in countries by 12/30/03.
- CAs arrange (in collaboration with POPTECH) country site visits for birthspacing assessment team by 1/14/04.
- For the CA only portion of the information collection process, CAs send preliminary country reports from data collected from CA staff to POPTECH by 1/20/04.
- CAs send the complete country reports, including the incorporation of information gathered from non–CA staff by 2/13/04.

COUNTRY QUESTIONS: Version 2.2

Introductory Instructions: The information sought in the sections below is based on your existing knowledge of service delivery programs and your experience. Please answer the questions below based on what you know (no new or additional data collection is required); simply use your familiarity of the program and your understanding of how programs operate to answer the questions. Completing the entire questionnaire is intended to be possible in minutes, not hours.

Country _____ Date_____

Main Questions

1. *The extent to which written policies, norms, standards, and/or training materials provide guidance on counseling families about the relationship between short intervals and mortality/morbidity risks for mother and child, and about optimal birth intervals and health and nutritional benefits. [a "policy" is defined as a written statement of expected practice or a common practice that is normally followed in the context of everyday service delivery work]*

   a) Is there a current policy articulating a recommended interval? If so, what is the recommended interval?

   b) Are there written standards or guidelines for service providers relating intervals to improved maternal and child health outcomes? If so, what does the guidance contain?

   c) Does inservice or preservice training for service providers commonly include instruction about recommended intervals and the relationship of such intervals to health benefits for women and children?

   d) Do job descriptions or desired job performance and supervisory protocols for service providers include any expectations about recommended intervals?

   e) Do counseling or client–provider interaction protocols provide guidance or tools for service providers for explaining the health benefits of optimal birthspacing? If so, and based on your experience or knowledge, what would you estimate the percentage of times counseling sessions for family planning clients interested in spacing normally include messages related to health benefits of recommended intervals?

2. *The extent relevant CAs, PVOs/NGOs, and ministries of health implement programs (including mass media, behavioral change, and community outreach) to educate women and men (including zero parity women and women in the postpartum/antenatal period) and/or providers about the risks of too short intervals and the health, nutritional, and other benefits of longer birth intervals*.

   a) If mass communication is used to promote, directly or indirectly, contraceptive use, do such campaigns include messages about the health benefits of optimal birth

intervals? If yes, about what percentage of the messages relate birth intervals to improved health?

b) In community outreach efforts or behavior change programs, are recommendations about birthspacing included? If so, is birthspacing clearly linked to improved health outcomes for women and children? If so, about what percentage of the effort or program is devoted to birthspacing and health improvements?

c) If such communication efforts include messages linking birthspacing to health improvements, is there any message containing information concerning or contraceptive options available for postponing a first birth (for married adolescents for whom postponing would have health benefits or others with an expressed interest in delaying a first birth)?

d) Are newly married or zero parity women identified as being part of the target audience?

3. *Important issues (access, quality, gender, knowledge, logistics/commodities, economic, other) that affect women's ability to achieve the birth intervals they prefer.*

a) Based on your experience and knowledge of the country as well as available data on unmet need for spacing, do you think there are barriers to a woman's ability to realize their interests? If so, what do you think are the most important issues or factors that limit women's ability to time pregnancies when they want?

b) If you identified an issue or limiting factors, are there any that can be addressed by improving the way providers or facilities offer services? If so, what improvement(s) do you think would be most important?

c) In your opinion, what are the most important factors that facilitate or hinder the ability of young (15–24), low parity (0–1) women to access family planning services to space or postpone a birth or pregnancy?

d) Are there country-specific data or research findings about why such barriers exist, their strength or prevalence? Is there any research or reports about why there is unmet need for spacing? If reports or findings exist about women's ability to exercise their preference for timing births or pregnancies, please list the references.

4. *Research available that indicates that women and men understand the concept of "planning and spacing births" and understandings of the concept "family planning." [question 4(c) is intended for managers and leaders of or service providers in organizations offering services*]

a) For the country or a part of the country, is there research or data available about the knowledge and level of understanding of the relationship of birth intervals and improved health for women and children among the reproductive age population?

b) In your opinion and based on your experience working and talking with providers, program managers and service delivery personnel, is the concept "family planning" most commonly related to demographic objectives (reducing population growth, etc.) or to health improvements?

c) In your experience, on any given day, what would you say is the portion (percentage) of the volume of services during common contraceptive service delivery activities that is related to timing of pregnancies for better health outcomes in women and children?

5. *Leaders and awareness of the relationship between birth intervals and child and maternal survival.*

   a) From your experience, are senior service delivery program leaders, decision-makers, and managers aware of the health benefits of recommended intervals?

   b) If so, do you believe progress in optimal birthspacing for improved health outcomes for women and children is commonly referenced or reported on to supervisors or to others in authority (such as funding organizations, MOH officials, USAID)?

   c) In your opinion, are program leaders or senior decision-makers aware of existing demand or unmet need for spacing births among young, low parity women?

   d) In your opinion, do you believe service delivery outlets commonly consider or define zero parity women as being "eligible" to receive contraceptive services or counseling about postponing a first birth?

6. *Current contraceptive method mix and women's birthspacing preferences in-country.*

   a) Given the current conceptive mix and popularity of commonly available contraceptives in your country, do you think sufficient method options exist for women to exercise choices?

   b) What is the most popular modern contraceptive method used by women?

   c) Is the use of traditional methods for birthspacing declining?

   d) Is EC [emergency contraception] readily available?

7. *Any evidence-based interventions/program models or data showing (a) improved FP one-year continuation rates; (b) greater ability for women (including zero parity women) to achieve the intervals/postponed births they desire; and/or (c) effective counseling of women in the postpartum period about the risks of too short intervals and the benefits of longer intervals.*

   a) In your country, have there been:

      - any improvements in family planning, one-year continuation rates?

      - increased percentage of women who have a met need for spacing?

      - programs/activities to counsel women in the postpartum period about the risk of too-short birth intervals and the health benefits of optimal intervals?

b) Can you attribute any of these changes to USAID–funded programs? If so, which program?

8. *Policy environment and any policy changes needed to facilitate and support improved birthspacing activities.*

   a) If the health benefits of improved birthspacing were to be realized in-country, do you think any policy changes would be required to maximize impact?

   b) If so, what is the most important policy change that you would recommend?

   c) What process would you recommend to enhance policies that would improve service delivery?

9. *Use of DHS and other survey data on data, including how are CAs, partners, and USAID using these data for monitoring and program improvements.*

   a) Are DHS or other comparable data sets regularly used to monitor birthspacing issues and progress?

   b) If so, how are such data related or applied to program progress and/or achievements toward health objectives?

   c) Are any interval indicators commonly used as a required reporting requirement for program results by host-country organizations or donors? If so, which indicators are used?

About the Respondent

Concerning your work and experience in-country, please provide the following information.

a) What type of service delivery networks do you work with most often:

   - Public sector (Ministry of Health, Social Security Administration, etc.)
   - Nongovernmental organization (family planning association, faith-based organization, etc.)
   - Commercial private sector (pharmacists, social marketing organization, private for-profit clinics, etc.)

b) How long have you been working in-country (number of years)?

c) What type of services do you work with most often? (family planning, safe motherhood, HIV/AIDS, child survival, PAC, etc.)

Note

The MEASURE Project is using DHS and other data to prepare a background profile for each country. Such country data profiles may include current spacing intervals (especially in the 15–24 age groups), women's preferred birth intervals, unmet need for spacing methods (including for zero parity women), FP one-year continuation rates, contraceptive prevalence for zero, one and two parity women, exclusive breastfeeding/LAM trends, and recent spacing and newborn/infant/child and maternal mortality and nutrition trends. So, you are not being asked to provide such information.

Illustrative
Summary Information Table
For __(country name)__

	No. of Responses			Comments
Question #	**Yes**	**No**	**N/A***	
1. a) first part				
1. b)				
1. c)				
1. d)				
1. e)				
4. a)				
4. b)				
5. a)				
5. b)				
5. c)				
5. d)				
6. a)				
6. c)				
6. d)				
8. a)				
9. a)				
9. c)				

* No Answer Given

APPENDIX D

TRAINING REVIEW CHECKLIST

TRAINING REVIEW CHECKLIST

A standardized checklist was used in the desk review of training materials submitted by various cooperating agencies. Following are the findings from the application of the checklist.

Optimal Birthspacing Initiative Desk Review Checklist
Document 1

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
1. The extent to which training materials, protocols, client–provider interaction documents, or other educational and outreach tools/strategy documents contain guidance that can be used by providers, supervisors, and managers to educate clients about the health and other benefits of spacing births three to five years, and the risks for mother and child of shorter intervals		
1.a.i. In training materials for counseling or promoting client–provider interaction, is the subject of the health benefits for women and children derived from optimal birth intervals covered?	✓ Yes No *Does not apply	
1.a.ii. If so, would you consider birthspacing for improved health outcomes to be effectively covered in these materials?	✓ Yes No *Does not apply	
1.b.i. In the tools that are available for providers to use when they counsel clients, is birthspacing for improved health outcomes addressed and present?	Yes No ✓ *Does not apply	These are training materials, not counseling tools per se.
1.b.ii. If so, would you consider the birthspacing element to be effectively covered in these tools?	Yes No ✓ *Does not apply	These are training materials, not counseling tools per se.
1.c.i. Does training for supervisors and managers typically include birthspacing for health improvement components?	Yes No ✓ *Does not apply	These are training materials for service providers, not specifically for supervisors and managers.
1.c.ii. If so, are these elements effectively incorporated in the training?	Yes No ✓ *Does not apply	These are training materials for service providers, not specifically for supervisors and managers.

* If the question does not apply to this document, explain why in the comments box.

2. How training materials reflect and incorporate the latest research findings on birthspacing		
2.a.i. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to maternal morbidity as well as mortality?	✓ Yes No *Does not apply	
2.a.ii. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to child morbidity and mortality?	✓ Yes No *Does not apply	
2.b. Does the training material discuss the potential needs of young (i.e., 15 to 24-year-old), low parity (i.e., parity of two or less) women?	Yes ✓ No *Does not apply	Although the materials address special contraceptive needs of adolescents, they do not specifically discuss optimal as it relates to young, low parity women.
2.c.i. Does training content include the concept that some zero parity women are interested in postponing their first birth?	Yes ✓ No *Does not apply	
2.c.ii. Does the training content recommend what counseling techniques can be effective for contraceptive choices for the zero parity women?	Yes ✓ No *Does not apply	
3.The relative effectiveness or "realism" of existing training approaches in covering birthspacing and optimal birth interval topics relative to improved health outcomes for women and children		
3.a.i. Given the known content and nature of existing training materials, do you think the trainees are currently acquiring sufficient knowledge or skills to articulate the health benefits of optimal birth intervals to clients or staff?	✓ Yes No *Does not apply	These materials provide a basic overview of optimal birthspacing.
3.a.ii. If not, why not?	Why not? ✓ *Does not apply	These materials provide a basic overview of optimal birthspacing.
3.b.i. In your opinion, is the length of training currently undertaken relevant to health benefits from birthspacing sufficient to enable service providers or program managers to effectively provide optimal birthspacing services (e.g., counseling and provision of a broad range of contraceptive methods in a variety of contexts, such as during prenatal and postpartum care)?	✓ Yes No *Does not apply	Key optimal birthspacing messages and information about providing a wide range of contraceptive methods in a variety of contexts are included as part of this 5–day, 10–session service provider family planning update workshop.

3.b.ii. If not, why not?	Why not? ✓ *Does not apply	Answer to previous question was "Yes."
4. Existing technical approaches for implementing the existing knowledge and best practices at the service delivery level		
4a. Do current training materials and/or approaches provide sufficient tools or methodologies for providers or program managers to practically improve services for birthspacing, particularly for young (i.e., 15 to 24-year-old), low parity (parity of two or less) women?	Yes No ✓ *Does not apply	These materials are designed to provide a general family planning overview rather than detailed training in optimal birthspacing.
4b. If not, why not?	Why not? ✓ *Does not apply	These materials are designed to provide a general family planning overview rather than a detailed training in optimal birthspacing.
4c. What would you recommend to strengthen the coverage of practical birthspacing service delivery in training?	Recommendations: *Does not apply	Develop a more detailed presentation about optimal birthspacing and provide optimal birthspacing counseling tools for providers to use with clients as part of the half-day session on family planning counseling.

Part II. Document Summary (all team members contribute to this section)

5a. Document number: 1

5b. Citation, including number of pages: [Citation removed for confidentiality.]

5c. Overall content: These training materials include information about contraceptive service delivery and the health benefits of family planning, with a particular focus on injectable contraceptives (DMPA), family planning counseling, hormonal contraceptives, natural family planning, voluntary surgical contraception, the copper T380A IUD, contraception for special circumstances, and infection prevention practices. These materials also provide updates on international efforts at identifying and implementing evidence-based practice for reducing barriers to access and quality for family planning services and the World Health Organization's medical eligibility criteria for contraceptive use. A special area covered in these materials is the use of auto-disable syringes for providing injectable contraceptives. In addition, these Family Planning Update materials also discuss the National Family Planning Program and policies of the Philippines.

5d. Overall purpose of document and countries of use: These materials were designed for use in a 5–day/10–session Family Planning Update (FPU) workshop. The purpose of the workshop is to update the technical knowledge and contraceptive service provision practices of service providers working in the public sector of the Department of Health of the Philippines.

5e. Summary of birthspacing information included in document: Includes a brief overview of birthspacing as one of the four basic principles of the Philippines National Family Planning Policy, gives the number of women in the Philippines who want to space pregnancies, mentions that three to five years is the optimal birthspacing interval to reduce morbidity and mortality of mothers and children, and mentions some of the research upon which optimal birthspacing is based.

Optimal Birthspacing Initiative Desk Review Checklist
Document 2

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
1. The extent to which training materials, protocols, client–provider interaction documents, or other educational and outreach tools/strategy documents contain guidance that can be used by providers, supervisors, and managers to educate clients about the health and other benefits of spacing births three to five years, and the risks for mother and child of shorter intervals		
1.a.i. In training materials for counseling or promoting client–provider interaction, is the subject of the health benefits for women and children derived from optimal birth intervals covered?	✓ Yes No *Does not apply	
1.a.ii. If so, would you consider birthspacing for improved health outcomes to be effectively covered in these materials?	✓ Yes No *Does not apply	
1.b.i. In the tools that are available for providers to use when they counsel clients, is birthspacing for improved health outcomes addressed and present?	✓ Yes No *Does not apply	
1.b.ii. If so, would you consider the birthspacing element to be effectively covered in these tools?	✓ Yes No *Does not apply	
1.c.i. Does training for supervisors and managers typically include birthspacing for health improvement components?	✓ Yes No *Does not apply	Although this manual was designed to include use by facility supervisors, the primary user is the skilled provider.
1.c.ii. If so, are these elements effectively incorporated in the training?	✓ Yes No *Does not apply	Some basic optimal birthspacing messages are included that may be used by clinical training and facility supervisors to assess and improve existing practices/systems or even develop new ones where needed.
2. How training materials reflect and incorporate the latest research findings on birthspacing		
2.a.i. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to maternal morbidity as well as mortality?	✓ Yes No *Does not apply	Says that intervals of at least three years between births lower the following **maternal** risks: mortality, anemia, premature rupture of membranes, postpartum endometritis, and malnutrition

* If the question does not apply to this document, explain why in the comments box.

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
2.a.ii. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to child morbidity and mortality?	✓ Yes No *Does not apply	Says that intervals of at least three years between births lower the following **fetal/newborn** risks: fetal death, preterm birth, small-for-gestational age baby, newborn death, and stunted and low birth weight baby
2.b. Does the training material discuss the potential needs of young (i.e., 15 to 24-year-old), low parity (i.e., parity of two or less) women?	Yes ✓ No *Does not apply	
2.c.i. Does training content include the concept that some zero parity women are interested in postponing their first birth?	Yes ✓ No *Does not apply	
2.c.ii. Does the training content recommend what counseling techniques can be effective for contraceptive choices for the zero parity women?	Yes ✓ No *Does not apply	
3.The relative effectiveness or "realism" of existing training approaches in covering birthspacing and optimal birth interval topics relative to improved health outcomes for women and children		
3.a.i. Given the known content and nature of existing training materials, do you think the trainees are currently acquiring sufficient knowledge or skills to articulate the health benefits of optimal birth intervals to clients or staff?	✓ Yes No *Does not apply	This material includes basic key messages about optimal intervals.
3.a.ii. If not, why not?	Why not? ✓ *Does not apply	Answered "yes" to previous question.
3.b.i. In your opinion, is the length of training currently undertaken relevant to health benefits from birthspacing sufficient to enable service providers or program managers to effectively provide optimal birthspacing services (e.g., counseling and provision of a broad range of contraceptive methods in a variety of contexts, such as during prenatal and postpartum care)?	✓ Yes No *Does not apply	The manual does not indicate the length of training; however, it is expected that this will be part of a complete learning resource package for a 2–week course (12–14 days). Given the fact that this will be a comprehensive course on basic maternal care, the amount of time devoted to optimal birthspacing information seems to be sufficient.

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
3.b.ii. If not, why not?	Why not? ✓ *Does not apply	Answered "yes" to previous question.
4. Existing technical approaches for implementing the existing knowledge and best practices at the service delivery level		
4a. Do current training materials and/or approaches provide sufficient tools or methodologies for providers or program managers to practically improve services for birthspacing, particularly for young (i.e., 15 to 24-year-old), low parity (parity of two or less) women?	Yes ✓ No *Does not apply	The manual does not give specific information about optimal birthspacing as it relates to young or low parity women.
4b. If not, why not?	Why not? *Does not apply	The optimal birthspacing messages in this manual are basic messages, intended for all women of childbearing age.
4c. What would you recommend to strengthen the coverage of practical birthspacing service delivery in training?	Recommendations: *Does not apply	Add to the existing optimal birthspacing messages by mentioning that optimal birthspacing should not be limited to older or high parity women. Rather, it is a service that should be made available to a woman of any reproductive age or parity, including young (15 to 24-year-old women, low parity (parity of two or less) women, and zero parity women who want to postpone their first birth.

Part II. Document Summary (all team members contribute to this section)

5a. Document number: 2

5b. Citation, including number of pages:[Citation removed for confidentiality.]

5c. Overall content: This manual provides detailed information about health care and newborn services that all childbearing women and newborns should receive. It covers care for women at any point during the childbearing cycle and for newborn babies during the first 6 days of life. It is part of a complete learning resource package that is currently under development.

5d. Overall purpose of document and countries of use: This manual is intended to serve as a foundation for the provision of basic care to women and newborns for the maintenance and promotion of their health as well as for assuring their survival. The following supporting goals are outlined in the four sections of the manual: promotion of health and prevention of disease, detection of existing diseases and treatment, early detection and management of complications, and birth preparedness and complication readiness. The manual is intended for use by skilled providers (including midwives, doctors, and nurses) who care for women and newborns in low-resource settings. Although the manual is intended primarily as a reference for the skilled provider, it can also be of use to both inservice and preservice education programs. Different parts of the manual may be used by a wide range of people in health care in a variety of ways. For example, facility supervisors may focus on certain sections for guidance in assessing and improving existing practices/systems or even for developing new practices/systems where needed.

5e. Summary of birthspacing information included in document: Birthspacing messages are found in several places throughout the manual. In a chapter that lays out the rationales for components of basic care, the table on rationales for elements of newborn history includes the message that birth less than 24 months since the previous birth is related to a higher incidence of newborn mortality. In this same chapter, the table on rationales for elements of maternal basic care provision includes the message that "During the childbearing cycle, women and their families think more and become more aware of the demands of a growing family—making this a good time to discuss family planning, and choosing the most appropriate family planning method for the woman offer many health benefits for her, her baby, and her partner." The chapter on antenatal care states that discussion about postpartum contraception options, including child spacing, should begin during the antenatal period.

Both the antenatal care and postpartum care chapters include the message that "intervals of at least 3 years have health benefits for both the woman and baby. Appropriate birthspacing lowers the risk of maternal mortality, anemia (woman), premature rupture of membranes (woman), postpartum endometritis (woman), malnutrition (woman), fetal death, preterm birth, small-for-gestational-age baby, newborn death, stunted and low birth weight baby."

An appendix that gives additional birth messages and counseling lists as one of the health benefits derived from breastfeeding the fact that exclusive breastfeeding helps delay another pregnancy. This appendix also includes the message that "many postpartum women want no more children or would like to delay pregnancy for at least 2 years," and states that "All postpartum women should be provided with family planning options."

Optimal Birthspacing Initiative Desk Review Checklist
Document 3

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
1. The extent to which training materials, protocols, client–provider interaction documents, or other educational and outreach tools/strategy documents contain guidance that can be used by providers, supervisors, and managers to educate clients about the health and other benefits of spacing births three to five years, and the risks for mother and child of shorter intervals		
1.a.i. In training materials for counseling or promoting client–provider interaction, is the subject of the health benefits for women and children derived from optimal birth intervals covered?	Yes ✓ No *Does not apply	Birthspacing messages warn against "closely spaced" births or pregnancies and "close birth intervals." Family planning benefits include helping to "space pregnancies adequately," or helping women to have children at the "right interval." However, optimal birth intervals (i.e., three to five years) are not specified.
1.a.ii. If so, would you consider birthspacing for improved health outcomes to be effectively covered in these materials?	Yes No ✓ *Does not apply	Optimal birth intervals are not specified.
1.b.i. In the tools that are available for providers to use when they counsel clients, is birthspacing for improved health outcomes addressed and present?	✓ Yes No *Does not apply	
1.b.ii. If so, would you consider the birthspacing element to be effectively covered in these tools?	✓ Yes No *Does not apply	
1.c.i. Does training for supervisors and managers typically include birthspacing for health improvement components?	✓ Yes No *Does not apply	
1.c.ii. If so, are these elements effectively incorporated in the training?	✓ Yes No *Does not apply	
2. How training materials reflect and incorporate the latest research findings on birthspacing		
2.a.i. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to maternal morbidity as well as mortality?	Yes No ✓ *Does not apply	Optimal birth intervals are not specified.

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
2.a.ii. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to child morbidity and mortality?	Yes No ✓ *Does not apply	Optimal birth intervals are not specified.
2.b. Does the training material discuss the potential needs of young (i.e., 15 to 24-year-old), low parity (i.e., parity of two or less) women?	✓ Yes No *Does not apply	Discusses special needs of adolescents and includes an appendix devoted to contraception for people under 18.
2.c.i. Does training content include the concept that some zero parity women are interested in postponing their first birth?	Yes ✓ No *Does not apply	
2.c.ii. Does the training content recommend what counseling techniques can be effective for contraceptive choices for the zero parity women?	Yes ✓ No *Does not apply	
3.The relative effectiveness or "realism" of existing training approaches in covering birthspacing and optimal birth interval topics relative to improved health outcomes for women and children		
3.a.i. Given the known content and nature of existing training materials, do you think the trainees are currently acquiring sufficient knowledge or skills to articulate the health benefits of optimal birth intervals to clients or staff?	Yes ✓ No *Does not apply	
3.a.ii. If not, why not?	Why not? *Does not apply	Optimal birth intervals are not specified.
3.b.i. In your opinion, is the length of training currently undertaken relevant to health benefits from birthspacing sufficient to enable service providers or program managers to effectively provide optimal birthspacing services (e.g., counseling and provision of a broad range of contraceptive methods in a variety of contexts, such as during prenatal and postpartum care)?	Yes No ✓ *Does not apply	This document is a policy document and not a training document per se. It does not give a specific length of training. Rather it provides general information and guidance that can be adapted for use in training at various levels of the health care system.

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
3.b.ii. If not, why not?	Why not? ✓ *Does not apply	This document is a policy document and not a training document per se. It does not give a specific length of training. Rather it provides general information and guidance that can be adapted for use in training at various levels of the health care system.
4. Existing technical approaches for implementing the existing knowledge and best practices at the service delivery level		
4a. Do current training materials and/or approaches provide sufficient tools or methodologies for providers or program managers to practically improve services for birthspacing, particularly for young (i.e., 15 to 24-year-old), low parity (parity of two or less) women?	✓ Yes No *Does not apply	
4b. If not, why not?	Why not? ✓ *Does not apply	Answered "yes" to previous question.
4c. What would you recommend to strengthen the coverage of practical birthspacing service delivery in training?	Recommendations: *Does not apply	Define optimal birth intervals as three to five years and include some evidence-based data and messages that explain why spacing births three to five years provides optimal health benefits for women and children.

Part II. Document Summary (all team members contribute to this section)

5a. Document number: 3

5b. Citation, including number of pages: [Citation removed for confidentiality.]

5c. Overall content: The document includes the following topics: national health policy; national reproductive health strategy; family planning and its role in national development goals; an overview of family planning methods; individual chapters on condoms, combined oral contraceptives, injectable contraceptives, IUDs, and traditional methods of family planning; counseling; client assessment; referrals; infection prevention; contraceptive logistics; and supervision and monitoring. It also includes appendices on the following topics: postpartum contraception, postabortion contraception, emergency contraception, contraception for people under 18, family planning and reproductive tract infections, rumors and facts about contraception, records, giving DMPA injection, steps for insertion and removal of Copper T380A IUD, and processing equipment and other items.

5d. Overall purpose of document and countries of use: This document provides national family planning service guidelines in Afghanistan. The document's objectives are to provide a basic reference document for family planning providers at all levels of health services; provide guidance for the following key categories: policymakers, health managers, and service providers; develop training materials for all health providers; and develop appropriate material for use in the community.

5e. Summary of birthspacing information included in document: This document provides many birthspacing messages in the following contexts: the national health policy, the national reproductive health strategy, family planning and its role in national development goals, provision of injectable contraceptives and IUDs, postpartum contraception, and contraception for people under 18.

Optimal Birthspacing Initiative Desk Review Checklist
Document 4

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
1. The extent to which training materials, protocols, client–provider interaction documents, or other educational and outreach tools/strategy documents contain guidance that can be used by providers, supervisors, and managers to educate clients about the health and other benefits of spacing births three to five years, and the risks for mother and child of shorter intervals		
1.a.i. In training materials for counseling or promoting client–provider interaction, is the subject of the health benefits for women and children derived from optimal birth intervals covered?	Yes ✓ No *Does not apply	
1.a.ii. If so, would you consider birthspacing for improved health outcomes to be effectively covered in these materials?	Yes No ✓ *Does not apply	Birthspacing not covered.
1.b.i. In the tools that are available for providers to use when they counsel clients, is birthspacing for improved health outcomes addressed and present?	Yes ✓ No *Does not apply	
1.b.ii. If so, would you consider the birthspacing element to be effectively covered in these tools?	Yes No ✓ *Does not apply	Birthspacing not covered.
1.c.i. Does training for supervisors and managers typically include birthspacing for health improvement components?	Yes No ✓ *Does not apply	The course is designed to train providers rather than supervisors and managers.
1.c.ii. If so, are these elements effectively incorporated in the training?	Yes No ✓ *Does not apply	The course is designed to train providers rather than supervisors and managers.
2. How training materials reflect and incorporate the latest research findings on birthspacing		
2.a.i. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to maternal morbidity as well as mortality?	Yes No ✓ *Does not apply	Birthspacing not covered.

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
2.a.ii. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to child morbidity and mortality?	Yes No ✓ *Does not apply	Birthspacing not covered.
2.b. Does the training material discuss the potential needs of young (i.e., 15 to 24-year-old), low parity (i.e., parity of two or less) women?	Yes ✓ No *Does not apply	Birthspacing not covered.
2.c.i. Does training content include the concept that some zero parity women are interested in postponing their first birth?	Yes ✓ No *Does not apply	
2.c.ii. Does the training content recommend what counseling techniques can be effective for contraceptive choices for the zero parity women?	Yes ✓ No *Does not apply	
3.The relative effectiveness or "realism" of existing training approaches in covering birthspacing and optimal birth interval topics relative to improved health outcomes for women and children		
3.a.i. Given the known content and nature of existing training materials, do you think the trainees are currently acquiring sufficient knowledge or skills to articulate the health benefits of optimal birth intervals to clients or staff?	Yes ✓ No *Does not apply	
3.a.ii. If not, why not?	Why not? *Does not apply	There is no reference to birthspacing in these checklists.
3.b.i. In your opinion, is the length of training currently undertaken relevant to health benefits from birthspacing sufficient to enable service providers or program managers to effectively provide optimal birthspacing services (e.g., counseling and provision of a broad range of contraceptive methods in a variety of contexts, such as during prenatal and postpartum care)?	Yes No ✓ *Does not apply	No training is included on the health benefits of birthspacing in these two checklists. These two checklists are just a small portion of the comprehensive 5–week course on emergency obstetric care. The current length of training should be sufficient to allow insertion of some optimal birthspacing messages that could be included during postabortion and postpartum family planning counseling.

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
3.b.ii. If not, why not?	Why not? ✓ *Does not apply	No training is included on the health benefits of birthspacing in these two checklists.
4. Existing technical approaches for implementing the existing knowledge and best practices at the service delivery level		
4a. Do current training materials and/or approaches provide sufficient tools or methodologies for providers or program managers to practically improve services for birthspacing, particularly for young (i.e., 15 to 24-year-old), low parity (parity of two or less) women?	Yes ✓ No *Does not apply	Birthspacing information not included in these checklists.
4b. If not, why not?	Why not? *Does not apply	The checklists were designed to provide emergency obstetric care for postpartum or postabortion women of any reproductive age or parity. Although general family planning counseling is included, the special needs of young, low parity women are not addressed.
4c. What would you recommend to strengthen the coverage of practical birthspacing service delivery in training?	Recommendations: *Does not apply	In the postpartum checklist, consider adding some optimal birthspacing messages to the family planning counseling step (step 5) under Care for Mother. In the postabortion family planning checklist, consider adding some optimal birthspacing messages to step 7 (when the provider discusses the woman's needs, concerns, and fears, and helps her begin to choose an appropriate family planning method).

Part II. Document Summary (all team members contribute to this section)

5a. Document number: 4

5b. Citation, including number of pages: [Citation removed for confidentiality.]

5c. Overall content: These checklists provide steps/tasks that the provider should perform when providing postpartum assessment and basic care or providing postabortion family planning counseling. They are used as part of a 5–week, comprehensive training in emergency obstetric care for doctors and midwives.

5d. Overall purpose of document and countries of use: Checklist to be used by the participant for practice and by the trainer at the end of the course.
It is one small part of a training course designed to train doctors, midwives, and/or nurses with midwifery skills who, as team members, will provide basic and comprehensive emergency obstetric care at district hospitals to avert maternal death and disability. The emphasis in this course is on rapid assessment and decision-making and clinical action steps based on clinical assessment with limited reliance on laboratory or other tests, suitable for district hospital and health centers in low resource settings.

5e. Summary of birthspacing information included in document: Neither of these checklists gives any birthspacing messages. A missed opportunity.

Optimal Birthspacing Initiative Desk Review Checklist
Document 5

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
1. The extent to which training materials, protocols, client–provider interaction documents, or other educational and outreach tools/strategy documents contain guidance that can be used by providers, supervisors, and managers to educate clients about the health and other benefits of spacing births three to five years, and the risks for mother and child of shorter intervals		
1.a.i. In training materials for counseling or promoting client–provider interaction, is the subject of the health benefits for women and children derived from optimal birth intervals covered?	Yes ✓ No *Does not apply	
1.a.ii. If so, would you consider birthspacing for improved health outcomes to be effectively covered in these materials?	Yes No ✓ *Does not apply	Health benefits for women and children derived from optimal birth intervals are not covered in this document.
1.b.i. In the tools that are available for providers to use when they counsel clients, is birthspacing for improved health outcomes addressed and present?	Yes ✓ No *Does not apply	General family planning counseling steps are included in two of the checklists: Immediate Postpartum Care, and Postpartum Care Six Days and Six Weeks After Delivery.
1.b.ii. If so, would you consider the birthspacing element to be effectively covered in these tools?	Yes ✓ No *Does not apply	
1.c.i. Does training for supervisors and managers typically include birthspacing for health improvement components?	Yes ✓ No *Does not apply	
1.c.ii. If so, are these elements effectively incorporated in the training?	Yes No ✓ *Does not apply	Birthspacing for health improvement components are not included in this document.
2. How training materials reflect and incorporate the latest research findings on birthspacing		
2.a.i. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to maternal morbidity as well as mortality?	Yes No ✓ *Does not apply	Birthspacing for health improvement components are not included in this document.
2.a.ii. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to child morbidity and mortality?	Yes No ✓ *Does not apply	Birthspacing for health improvement components are not included in this document.

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
2.b. Does the training material discuss the potential needs of young (i.e., 15 to 24-year-old), low parity (i.e., parity of two or less) women?	Yes ✓ No *Does not apply	
2.c.i. Does training content include the concept that some zero parity women are interested in postponing their first birth?	Yes ✓ No *Does not apply	
2.c.ii. Does the training content recommend what counseling techniques can be effective for contraceptive choices for the zero parity women?	Yes ✓ No *Does not apply	
3.The relative effectiveness or "realism" of existing training approaches in covering birthspacing and optimal birth interval topics relative to improved health outcomes for women and children		
3.a.i. Given the known content and nature of existing training materials, do you think the trainees are currently acquiring sufficient knowledge or skills to articulate the health benefits of optimal birth intervals to clients or staff?	Yes ✓ No *Does not apply	
3.a.ii. If not, why not?	Why not? *Does not apply	Information about the health benefits of optimal birth intervals is not included in this document. A missed opportunity.
3.b.i. In your opinion, is the length of training currently undertaken relevant to health benefits from birthspacing sufficient to enable service providers or program managers to effectively provide optimal birthspacing services (e.g., counseling and provision of a broad range of contraceptive methods in a variety of contexts, such as during prenatal and postpartum care)?	Yes No ✓ *Does not apply	Currently, no training is undertaken relevant to the health benefits from birthspacing.
3.b.ii. If not, why not?	Why not? ✓ *Does not apply	Currently, no training is undertaken relevant to the health benefits from birthspacing. However, key birthspacing messages could be added without significantly affecting the length of training.
4. Existing technical approaches for implementing the existing knowledge and best practices at the service delivery level		
4a. Do current training materials and/or approaches provide sufficient tools or methodologies for providers or program managers to practically improve services for birthspacing, particularly for young (i.e., 15 to 24-year-old), low parity (parity of two or less) women?	Yes ✓ No *Does not apply	

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
4b. If not, why not?	Why not? *Does not apply	The document addresses all women of childbearing age and does not focus on any specific age or parity.
4c. What would you recommend to strengthen the coverage of practical birthspacing service delivery in training?	Recommendations: Consider adding key optimal birthspacing messages when the provider gives the client family planning counseling during immediate postpartum care, and during postpartum care 6 days and 6 weeks after childbirth. If birthspacing messages are included during antenatal family planning counseling, they should be tailored in a way that will not be upsetting to a woman who is currently carrying a closely spaced baby. *Does not apply	The following places in the document might be appropriate places to add optimal birthspacing messages: Antenatal Care Checklist step, in which the provider identifies individual problems/needs of the woman based on her history, antenatal exam, and screening procedure; Antenatal Care Checklist step 5 under Furnishing Care/Taking Action when the provider provides counseling on necessary topics; Immediate Postpartum Care Checklist, step 14, under Visit 6 Hours after Childbirth, in which the provider furnishes family planning counseling and provides a contraceptive method, if appropriate; Postpartum Care Six Days and Six Weeks After Childbirth, Step 6 under Provider Care/Take Action (Care of the Mother), in which the provider furnishes family planning counseling and helps the woman choose an appropriate contraceptive method.

Part II. Document Summary (all team members contribute to this section)

5a. Document number: 5

5b. Citation, including number of pages: [Citation removed for confidentiality.]

5c. Overall content: A guide for supervisors to use in evaluating provider performance during site visits. The guide includes checklists for Antenatal Care, Evaluation of a Woman during Labor, Supervision of Labor with the Partograph, Carrying Out a Clean and Safe Childbirth, Newborn Care, Immediate Postpartum Care, Postpartum Care Six Days and Six Weeks After Delivery, Newborn Resuscitation, Repair of First and Second-Degree Perinatal Tears, Episiotomy and Repair, Artificial Delivery, Bimanual Compression of the Uterus, Infection Prevention, and Use of Service Statistics.

5d. Overall purpose of document and countries of use: This guide is used in Burkina Faso during provider update and standardization training.

5e. Summary of birthspacing information included in document: There are no birthspacing messages in this document. General family planning counseling steps are included in two of the checklists: Immediate Postpartum Care, and Postpartum Care Six Days and Six Weeks After Delivery.

Optimal Birthspacing Initiative Desk Review Checklist
Document 6

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
1. The extent to which training materials, protocols, client–provider interaction documents, or other educational and outreach tools/strategy documents contain guidance that can be used by providers, supervisors, and managers to educate clients about the health and other benefits of spacing births three to five years, and the risks for mother and child of shorter intervals		
1.a.i. In training materials for counseling or promoting client–provider interaction, is the subject of the health benefits for women and children derived from optimal birth intervals covered?	Yes ✓ No *Does not apply	
1.a.ii. If so, would you consider birthspacing for improved health outcomes to be effectively covered in these materials?	Yes No ✓ *Does not apply	Optimal birthspacing is not covered.
1.b.i. In the tools that are available for providers to use when they counsel clients, is birthspacing for improved health outcomes addressed and present?	Yes ✓ No *Does not apply	Although using family planning for spacing purposes is generally referred to in counseling materials, spacing is not specifically linked to improved health outcomes.
1.b.ii. If so, would you consider the birthspacing element to be effectively covered in these tools?	Yes No ✓ *Does not apply	Birthspacing is not a major focus of this curriculum.
1.c.i. Does training for supervisors and managers typically include birthspacing for health improvement components?	Yes ✓ No *Does not apply	Although supervisors and managers are addressed in this curriculum, the materials do not describe optimal birthspacing or link birthspacing to health improvement components.
1.c.ii. If so, are these elements effectively incorporated in the training?	Yes No ✓ *Does not apply	Answered “no” to previous question.
2. How training materials reflect and incorporate the latest research findings on birthspacing		
2.a.i. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to maternal morbidity as well as mortality?	Yes No ✓ *Does not apply	Does not cover the concept of optimal birthspacing.
2.a.ii. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to child morbidity and mortality?	Yes No ✓ *Does not apply	Does not cover the concept of optimal birthspacing.

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
2.b. Does the training material discuss the potential needs of young (i.e., 15 to 24-year-old), low parity (i.e., parity of two or less) women?	Yes ✓ No *Does not apply	Although special needs of adolescents are generally addressed, optimal birthspacing is not mentioned. Special needs of young, low parity women (other than adolescents) are not addressed.
2.c.i. Does training content include the concept that some zero parity women are interested in postponing their first birth?	Yes ✓ No *Does not apply	
2.c.ii. Does the training content recommend what counseling techniques can be effective for contraceptive choices for the zero parity women?	Yes ✓ No *Does not apply	
3.The relative effectiveness or "realism" of existing training approaches in covering birthspacing and optimal birth interval topics relative to improved health outcomes for women and children		
3.a.i. Given the known content and nature of existing training materials, do you think the trainees are currently acquiring sufficient knowledge or skills to articulate the health benefits of optimal birth intervals to clients or staff?	Yes ✓ No *Does not apply	Does not cover the health benefits of optimal birth intervals.
3.a.ii. If not, why not?	Why not? *Does not apply	At the time this curriculum was developed, it appears that the concept of optimal birthspacing was not identified by the authors as a component of integrated sexual and reproductive health counseling.
3.b.i. In your opinion, is the length of training currently undertaken relevant to health benefits from birthspacing sufficient to enable service providers or program managers to effectively provide optimal birthspacing services (e.g., counseling and provision of a broad range of contraceptive methods in a variety of contexts, such as during prenatal and postpartum care)?	Yes No ✓ *Does not apply	This curriculum is designed as a 6–day workshop for providers that can be adapted for use as a 2–day workshop for frontline staff, and either a 6–day or a 3–day workshop for administrators and supervisors. The curriculum covers counseling and provision of a broad range of contraceptive methods in a variety of contexts (e.g., during prenatal and postpartum care); however, optimal birthspacing messages are not included. This is a missed opportunity.

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
3.b.ii. If not, why not?	Why not? ✓ *Does not apply	Optimal birthspacing is not incorporated in this curriculum.
4. Existing technical approaches for implementing the existing knowledge and best practices at the service delivery level		
4a. Do current training materials and/or approaches provide sufficient tools or methodologies for providers or program managers to practically improve services for birthspacing, particularly for young (i.e., 15 to 24-year-old), low parity (parity of two or less) women?	Yes ✓ No *Does not apply	Although the need for adolescents to prevent unintended pregnancy is addressed, the birthspacing needs of young, low parity women are not addressed.
4b. If not, why not?	Why not? *Does not apply	At the time this curriculum was developed, it appears that birthspacing services for young, low parity women were not identified by the authors as a component of integrated sexual and reproductive health counseling.
4c. What would you recommend to strengthen the coverage of practical birthspacing service delivery in training?	Recommendations: *Does not apply	The curriculum includes sample client profiles for participants to adapt for use in their local settings. It might be a good idea to include several sample client profiles about clients who are interested in spacing their pregnancies to achieve optimal health benefits for themselves and their children. Birthspacing profiles could include a zero parity, 15 to 24-year-old woman, a postpartum woman, and a postabortion woman. Optimal birthspacing educational materials could be included among the props listed for use in client–provider role plays.

Part II. Document Summary (all team members contribute to this section)

5a. Document number: 6

5b. Citation, including number of pages: [Citation removed for confidentiality.]

5c. Overall content: This training curriculum covers knowledge, attitudes, and skills necessary for participants to carry out the following key counseling tasks: help clients assess their own needs for a range of sexual and reproductive health services, information, and emotional support; provide information appropriate to clients' identified problems and needs; assist clients in making their own voluntary and informed decisions; and help clients develop the skills they will need to carry out those decisions.

5d. Overall purpose of document and countries of use: This curriculum is intended to respond to the identified gap in existing training materials and to fill a field-expressed need for help in developing knowledge about, skills in, attitudes toward, and comfort with effective communication and counseling in all areas of reproductive health, including sexuality. It is intended for health care providers, their supervisors, and the managers of the programs in which they work. The goal of this training is to enable providers to address clients' comprehensive sexual and reproductive health needs by offering integrated sexual and reproductive health counseling services within their own particular service delivery setting.

5e. Summary of birthspacing information included in document: The trainer's manual includes "spacing" as a reproductive right, per the 1994 International Conference on Population and Development (ICPD) definition. Among clients' rights, the manual includes the right to decide ***when*** to have children and suggests that this right, along with the right to decide how many children to have, can strengthen respect and value for the family. It includes a GATHER observation checklist that includes asking the client about "spacing of births." The participant's handbook cites the ICPD definition of reproductive health, which includes the freedom to decide ***when*** to reproduce. The handbook includes "spacing" of children as a reproductive right. In defining the concept of informed and voluntary decision-making, the handbook includes the following spacing-related decisions, among a variety of client decisions: "whether to use contraception after delivery and ***when*** to start (contraception)" for maternal health care, the decision to ***delay*** future pregnancies for postabortion care, and the decision to ***delay*** and ***space*** childbearing for family planning. The handbook mentions that "in some cultures, couples are increasingly choosing ***to delay childbirth***." In a list of topics designed to guide providers in formulating open-ended client counseling questions, the handbook includes asking clients about their reproductive intentions, including "timing of pregnancies." This list also includes asking antenatal and postpartum clients about "contraception after pregnancy," and asking postabortion clients about "contraception after procedure." Among key messages for integrated sexual and reproductive health counseling, the handbook mentions "contraception after delivery," postpartum contraception, and postabortion ***delay*** of future pregnancies. Under IUD counseling, client's perception of risk, the handbook mentions a client's potential fear of "a pregnancy too soon." As part of a section on effective client questioning, the handbook includes asking the question, "How would you feel if you became pregnant soon?" A counseling guide for combined oral contraceptives includes the question, "Do you especially want to ***postpone*** or to ***space births***?" Among individual factors for family planning counseling during postabortion care, the handbook includes, "if the woman does not want to be pregnant ***soon***." The handbook includes family planning counseling during maternal health care. It states that "plans should be made for a family planning strategy after childbirth," and that during the second trimester, "the importance of family planning after delivery" should be discussed as a key issue. And during the third trimester, "family planning after delivery" should be discussed again. For postpartum counseling for the mother's health, the handbook includes being "supportive of the couple's adopting a contraceptive method."

Optimal Birthspacing Initiative Desk Review Checklist
Document 7

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
1. The extent to which training materials, protocols, client–provider interaction documents, or other educational and outreach tools/strategy documents contain guidance that can be used by providers, supervisors, and managers to educate clients about the health and other benefits of spacing births three to five years, and the risks for mother and child of shorter intervals		
1.a.i. In training materials for counseling or promoting client–provider interaction, is the subject of the health benefits for women and children derived from optimal birth intervals covered?	Yes ✓ No *Does not apply	Birthspacing is mentioned only in general terms. Although health problems caused by complications from too early pregnancy in adolescents is mentioned, optimal spacing to maximize health benefits for women and children is not covered.
1.a.ii. If so, would you consider birthspacing for improved health outcomes to be effectively covered in these materials?	Yes No ✓ *Does not apply	The concept of optimal birthspacing for improved health outcomes is not covered.
1.b.i. In the tools that are available for providers to use when they counsel clients, is birthspacing for improved health outcomes addressed and present?	Yes ✓ No *Does not apply	
1.b.ii. If so, would you consider the birthspacing element to be effectively covered in these tools?	Yes No ✓ *Does not apply	The concept of birthspacing for improved health outcomes is not covered in the counseling tools.
1.c.i. Does training for supervisors and managers typically include birthspacing for health improvement components?	Yes No ✓ *Does not apply	This curriculum is intended for service providers and does not provide training for supervisors and managers.
1.c.ii. If so, are these elements effectively incorporated in the training?	Yes No ✓ *Does not apply	This curriculum is intended for service providers and does not provide training for supervisors and managers.
2. How training materials reflect and incorporate the latest research findings on birthspacing		
2.a.i. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to maternal morbidity as well as mortality?	Yes No ✓ *Does not apply	The concept of optimal birthspacing for improved health outcomes is not covered.

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
2.a.ii. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to child morbidity and mortality?	Yes No ✓ *Does not apply	The concept of optimal birthspacing for improved health outcomes is not covered.
2.b. Does the training material discuss the potential needs of young (i.e., 15 to 24-year-old), low parity (i.e., parity of two or less) women?	✓ Yes No *Does not apply	The curriculum does acknowledge the special needs of adolescents (both married and unmarried), teenagers, and young people. Health problems caused by complications from too early pregnancy in adolescents is briefly mentioned.
2.c.i. Does training content include the concept that some zero parity women are interested in postponing their first birth?	Yes ✓ No *Does not apply	
2.c.ii. Does the training content recommend what counseling techniques can be effective for contraceptive choices for the zero parity women?	Yes ✓ No *Does not apply	
3.The relative effectiveness or "realism" of existing training approaches in covering birthspacing and optimal birth interval topics relative to improved health outcomes for women and children		
3.a.i. Given the known content and nature of existing training materials, do you think the trainees are currently acquiring sufficient knowledge or skills to articulate the health benefits of optimal birth intervals to clients or staff?	Yes ✓ No *Does not apply	
3.a.ii. If not, why not?	Why not? *Does not apply	The references to birthspacing are very general and do not include the most recent findings.
3.b.i. In your opinion, is the length of training currently undertaken relevant to health benefits from birthspacing sufficient to enable service providers or program managers to effectively provide optimal birthspacing services (e.g., counseling and provision of a broad range of contraceptive methods in a variety of contexts, such as during prenatal and postpartum care)?	Yes ✓ No *Does not apply	The references to birthspacing are very general and do not include the most recent findings.

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
3.b.ii. If not, why not?	Why not? *Does not apply	There are many missed opportunities during sessions in the 6–day curriculum, during which optimal birthspacing messages could be very effectively included.
4. Existing technical approaches for implementing the existing knowledge and best practices at the service delivery level		
4a. Do current training materials and/or approaches provide sufficient tools or methodologies for providers or program managers to practically improve services for birthspacing, particularly for young (i.e., 15 to 24-year-old), low parity (parity of two or less) women?	Yes ✓ No *Does not apply	
4b. If not, why not?	Why not? *Does not apply	Although the curriculum offers very intensive training in counseling skills, it does not introduce any session materials, client profiles, or client situations that address optimal birthspacing and its benefits.

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
4c. What would you recommend to strengthen the coverage of practical birthspacing service delivery in training? There are many opportunities throughout this 6–day curriculum that could be seized to provide appropriate information about the health benefits of optimal birthspacing. This 6–day workshop is designed to give an overview of counseling approaches and skills. One-day, inservice follow-on modules are intended as options to provide detailed information about each counseling area after this workshop. A detailed optimal birthspacing module could be developed as a potential 1–day, follow-on training option. (See recommendations and comments for detailed suggestions.)	4.c Recommendations: An optimal birthspacing question could be included on the pre/post test; client profiles and situation cards that are included in case studies and role plays throughout the workshop could introduce and define the term optimal birthspacing, and client situations could be included that illustrate a variety of birthspacing counseling opportunities for women at various stages in their reproductive life. The idea of including optimal birthspacing messages as part of group education sessions prior to counseling could be added in part II, p. 51. In the session on "Giving Reasons–Preventing and Handling Misconceptions," optimal birthspacing could be added as one of the sample health messages (part II, p. 59), and a misconception card about optimal birthspacing could be added to the small group exercise that deals with handling misconceptions that prevail in the local community (part II, p. 61). Designing simple print materials about optimal birthspacing for the client to take home could be included on the page that addresses "Helping Clients Remember the Information" (part II, p. 70).	In the session on "Decision-Making: Factors in Client Decisions," the example of a 19-year-old woman who has just been married and wants to postpone her first baby could be added (part II, p. 79). The desire to space births could be added to the first bullet on p. 80 of part II that lists "individual factors that influence decision-making," or to the fifth bullet that reminds providers that each client has "different reproductive goals at different times in his or her life." Optimal birthspacing messages could be added to messages that can be given by nonmedical staff as part of the team approach to counseling (part II, p. 101) during intake and group education talks prior to counseling. A 1–page sheet that describes optional birthspacing could be added to the session in part III that provides "Counseling Content for Specific Issues or Categories of Individuals." In part III, p. 23, "spacing of births" could be added to one of the bullets that describe areas in which a woman may have a "lack of bargaining power with her partner." The health benefits of optimal birthspacing could be used as an example of something to be addressed in the "Seizing Opportunities" table in part III, p. 33, that gets providers to consider the question, "What does this client need to know about areas other than the one for which he/she sought services?"

Part II. Document Summary (all team members contribute to this section)

5a. Document number: 7

5b. Citation, including number of pages: [Citation removed for confidentiality.]

5c. Overall content: This document provides a 6–day workshop curriculum for developing provider counseling skills. This curriculum presents a holistic counseling approach that expands the concept of family planning counseling to attend to the client's full range of sexual and reproductive health needs.

5d. Overall purpose of document and countries of use: To prepare service providers to identify and address clients' comprehensive sexual and reproductive health counseling needs, regardless of what health service they are working within, or what service the client has requested.

5e. Summary of birthspacing information included in document: This document lists among other reproductive health indicators the "unmet need for spacing," which it describes as including "pregnant women whose pregnancy was **mistimed**, amenorrheic women whose last birth was **mistimed**, and women who are neither pregnant nor amenorrheic and who are not using any method of family planning but say they **want to wait two or more years for their next birth**." The document includes the WHO definition of reproductive health, which implies that people have "the freedom to decide if, **when** and how often to [reproduce]." The document includes, as an "essential idea to convey," "the right to decide on number, **spacing**, and timing of children and "the right to have information and means to do so." In a session on "Decision-making: Factors in Client Decisions," the following is included as a key discussion point: "How do reproductive goals change throughout the lifecycle? (**Postponing or spacing pregnancy**, ending childbearing)." A page on "SRH [sexual and reproductive health] Counseling for Adolescents" states that "Health services for adolescents can prevent serious health problems and premature deaths due to complications from a **too-early pregnancy** or an unsafe abortion."

Optimal Birthspacing Initiative Desk Review Checklist
Document 8

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
1. The extent to which training materials, protocols, client–provider interaction documents, or other educational and outreach tools/strategy documents contain guidance that can be used by providers, supervisors, and managers to educate clients about the health and other benefits of spacing births three to five years, and the risks for mother and child of shorter intervals		
1.a.i. In training materials for counseling or promoting client–provider interaction, is the subject of the health benefits for women and children derived from optimal birth intervals covered?	Yes ✓ No *Does not apply	
1.a.ii. If so, would you consider birthspacing for improved health outcomes to be effectively covered in these materials?	Yes No ✓ *Does not apply	Although the term "birthspacing" is used throughout the document to refer to family planning, and a link between birthspacing and health benefits is made, the specific health benefits of optimal (three to five years) birthspacing are not covered.
1.b.i. In the tools that are available for providers to use when they counsel clients, is birthspacing for improved health outcomes addressed and present?	✓ Yes No *Does not apply	Yes, in general terms.
1.b.ii. If so, would you consider the birthspacing element to be effectively covered in these tools?	Yes ✓ No *Does not apply	The birthspacing messages are not SOTA. For example, one of the documents refers to women who have children very close together, at less than two-year intervals, as a target group for family planning. This message needs to be expanded and updated to "less than three-year intervals."
1.c.i. Does training for supervisors and managers typically include birthspacing for health improvement components?	Yes No ✓ *Does not apply	This training is for providers, not supervisors and managers.

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
1.c.ii. If so, are these elements effectively incorporated in the training?	Yes No ✓ *Does not apply	This training is for providers, not supervisors and managers.
2. How training materials reflect and incorporate the latest research findings on birthspacing		
2.a.i. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to maternal morbidity as well as mortality?	Yes No ✓ *Does not apply	Although the birthspacing program is linked to the improvement of child and maternal health in Cambodia, the training materials do not cover the concept of optimal birthspacing.
2.a.ii. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to child morbidity and mortality?	Yes No ✓ *Does not apply	Although the birthspacing program is linked to the improvement of child and maternal health in Cambodia, the training materials do not cover the concept of optimal birthspacing.
2.b. Does the training material discuss the potential needs of young (i.e., 15 to 24-year-old), low parity (i.e., parity of two or less) women?	✓ Yes No *Does not apply	The material does include women younger than 18 years as one of the four target groups for family planning.
2.c.i. Does training content include the concept that some zero parity women are interested in postponing their first birth?	Yes ✓ No *Does not apply	
2.c.ii. Does the training content recommend what counseling techniques can be effective for contraceptive choices for the zero parity women?	Yes ✓ No *Does not apply	
3.The relative effectiveness or "realism" of existing training approaches in covering birthspacing and optimal birth interval topics relative to improved health outcomes for women and children		
3.a.i. Given the known content and nature of existing training materials, do you think the trainees are currently acquiring sufficient knowledge or skills to articulate the health benefits of optimal birth intervals to clients or staff?	Yes ✓ No *Does not apply	

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
3.a.ii. If not, why not?	Why not? *Does not apply	Up-to-date, evidence-based information about the health benefits of optimal birthspacing is not included in the training material.
3.b.i. In your opinion, is the length of training currently undertaken relevant to health benefits from birthspacing sufficient to enable service providers or program managers to effectively provide optimal birthspacing services (e.g., counseling and provision of a broad range of contraceptive methods in a variety of contexts, such as during prenatal and postpartum care)?	Yes ✓ No *Does not apply	
3.b.ii. If not, why not?	Why not? *Does not apply	There is no time during the current training events (a variety of training events which appear to range from 1 to 3 to 6 days) in which optimal birthspacing services are clearly defined.
4. Existing technical approaches for implementing the existing knowledge and best practices at the service delivery level		
4a. Do current training materials and/or approaches provide sufficient tools or methodologies for providers or program managers to practically improve services for birthspacing, particularly for young (i.e., 15 to 24-year-old), low parity (parity of two or less) women?	Yes ✓ No *Does not apply	
4b. If not, why not?	Why not? *Does not apply	Birthspacing services for young, low parity women are not clearly defined.
4c. What would you recommend to strengthen the coverage of practical birthspacing service delivery in training?	Recommendations : *Does not apply	Add messages that clearly define the maternal and child health benefits of optimal birthspacing. In the session that includes an exercise to identify suitable birthspacing methods for different client needs, include an example of a client who is in need of optimal birthspacing counseling. Add birthspacing materials to currently existing promotional materials used in the training. Add as one of the counseling role play situations a client who needs information about optimal birthspacing.

Part II. Document Summary (all team members contribute to this section)

5a. Document number: 8

5b. Citation, including number of pages: [Citation removed for confidentiality.]

5c. Overall content: These documents are reproductive health training agendas and session plans. Methods of focus in the training are condoms, combined oral contraceptives, and Depo-Provera injections.

5d. Overall purpose of document and countries of use: These materials have been used to (1) train NGO partners in birthspacing promotion and HIV education (under the United Health Network), (2) train medical providers (medical doctors, assistants, nurses, and midwives) across the country in the use of combined oral contraceptives and Depo-Provera injections, and (3) train a franchised network of private medical providers in birthspacing counseling and birthspacing methods available in Cambodia. An array of materials is used to support this training, which were not examined because they are all in Khmer. These materials are often adapted from existing tools available in English, such as an informed choice poster.

5e. Summary of birthspacing information included in document: The term is used throughout these documents when referring to overall family planning programs, family planning training, family planning methods, family planning services, and client family planning needs. The *Session Plan for Training on HIV/AIDS and for Health Unlimited Staff* includes a 60–minute session, which includes as one of its objectives, providing "clear information about the relationship between maternal and child mortality and high-risk factors of maternal age, birth order, and **birth interval**." This session ask participants to "identify four important target groups for family planning: 1. women younger than 18 years; 2. women [who] have large numbers of children (six and above); 3. **women [who] have children very close together (less than two-year interval)**; and 4. older women (40+ years). One of the training documents gives statistics that indicate that there is a high demand for birthspacing methods in Cambodia; of 15 to 49-year-old women in Cambodia, only 29 percent (National Health Survey [NHS] 1998) or 9.8 percent (Demographic Health Survey [DHS] 2000) or want more children. Another document mentions the low contraceptive prevalence in Cambodia.

Optimal Birthspacing Initiative Desk Review Checklist
Document 9

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
1. The extent to which training materials, protocols, client–provider interaction documents, or other educational and outreach tools/strategy documents contain guidance that can be used by providers, supervisors, and managers to educate clients about the health and other benefits of spacing births three to five years, and the risks for mother and child of shorter intervals		
1.a.i. In training materials for counseling or promoting client–provider interaction, is the subject of the health benefits for women and children derived from optimal birth intervals covered?	✓ Yes No *Does not apply	
1.a.ii. If so, would you consider birthspacing for improved health outcomes to be effectively covered in these materials?	Yes ✓ No *Does not apply	
1.b.i. In the tools that are available for providers to use when they counsel clients, is birthspacing for improved health outcomes addressed and present?	✓ Yes No *Does not apply	
1.b.ii. If so, would you consider the birthspacing element to be effectively covered in these tools?	Yes ✓ No *Does not apply	
1.c.i. Does training for supervisors and managers typically include birthspacing for health improvement components?	Yes No ✓ *Does not apply	Although some aspects of supervision and management are mentioned in the document, the primary user is the service provider.
1.c.ii. If so, are these elements effectively incorporated in the training?	Yes No ✓ *Does not apply	Although some aspects of supervision and management are mentioned in the document, the primary user is the service provider.
2. How training materials reflect and incorporate the latest research findings on birthspacing		
2.a.i. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to maternal morbidity as well as mortality?	✓ Yes No *Does not apply	

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
2.a.ii. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to child morbidity and mortality?	✓ Yes No *Does not apply	
2.b. Does the training material discuss the potential needs of young (i.e., 15 to 24-year-old), low parity (i.e., parity of two or less) women?	✓ Yes No *Does not apply	
2.c.i. Does training content include the concept that some zero parity women are interested in postponing their first birth?	✓ Yes No *Does not apply	
2.c.ii. Does the training content recommend what counseling techniques can be effective for contraceptive choices for the zero parity women?	Yes ✓ No *Does not apply	
3.The relative effectiveness or "realism" of existing training approaches in covering birthspacing and optimal birth interval topics relative to improved health outcomes for women and children		
3.a.i. Given the known content and nature of existing training materials, do you think the trainees are currently acquiring sufficient knowledge or skills to articulate the health benefits of optimal birth intervals to clients or staff?	Yes ✓ No *Does not apply	
3.a.ii. If not, why not?	Why not? *Does not apply	The manual was published in 1994 and needs to be updated to include the latest findings from optimal birthspacing studies.
3.b.i. In your opinion, is the length of training currently undertaken relevant to health benefits from birthspacing sufficient to enable service providers or program managers to effectively provide optimal birthspacing services (e.g., counseling and provision of a broad range of contraceptive methods in a variety of contexts, such as during prenatal and postpartum care)?	Yes ✓ No *Does not apply	

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
3.b.ii. If not, why not?	Why not? *Does not apply	This curriculum is designed for a 4–week, 5 days per week training period, divided between theory (class work) and clinical practice. This training period should be sufficient to provide ample birthspacing messages; however, though ample birthspacing messages are given, these could be strengthened by adding evidence-based findings from recent optimal birthspacing studies.
4. Existing technical approaches for implementing the existing knowledge and best practices at the service delivery level		
4a. Do current training materials and/or approaches provide sufficient tools or methodologies for providers or program managers to practically improve services for birthspacing, particularly for young (i.e., 15 to 24-year-old), low parity (parity of two or less) women?	Yes ✓ No *Does not apply	The manual does mention among high-risk pregnancies those that occur "too early," that is, "in women who are under 18 years of age." The manual also states that in these pregnancies, "the mother's physical immaturity, especially incomplete development of the pelvis, is the major cause of maternal and infant mortality and morbidity rates. Poor health and poverty may exacerbate a premature birth." The manual includes as part of the service provider's role the "need to identify missed opportunities when they can provide the youth with information on family planning." Unfortunately, the manual lists "nulliparous women below the age of 20 years" among clients who are contraindicated for use of Norplant implants.

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
4b. If not, why not?	Why not? *Does not apply	Although the manual recognizes the missed opportunities that occur "when youth visit the clinics for other reasons," and "when parents attend service facilities seeking information on youth services," it does not give specific guidance on how providers and program managers can improve birthspacing services for these particular clients.
4c. What would you recommend to strengthen the coverage of practical birthspacing service delivery in training?	Recommendations: *Does not apply	In the module on client management, consider including detailed information about the latest findings regarding optimal birthspacing, and include a case study or role play that focuses on providing optimal birthspacing messages to a potential family planning client.

Part II. Document Summary (all team members contribute to this section)

5a. Document number: 9

5b. Citation, including number of pages: [Citation removed for confidentiality.]

5c. Overall content: This manual is an updated and revised version of the 1984 Zimbabwe *Family Planning Clinical Training Manual*. This revised document was produced as part of an effort to expand the service delivery capability and introduce new methods and approaches to contraception.

5d. Overall purpose of document and countries of use: The overall goal of this document is to upgrade and strengthen the knowledge, attitude, and practical skills of nurses and doctors to enable them to provide quality family planning services through an integrated approach. The major objective of this course is to strengthen integrated MCH/FP services offered throughout Zimbabwe. This training has been offered as an inservice program to qualified nurses and doctors and integrated in the preservice training of general nurses and midwives. This is a competency-based curriculum that has been designed as a guide for family planning trainers to provide family planning training in training centers distributed throughout Zimbabwe.

5e. Summary of birthspacing information included in document: The foreword states that one reason this training manual was revised was because findings of the 1988 DHS indicated that "current married women who wished to stop or **delay** pregnancies were not doing so because of the inaccessibility of family planning services." The session on "Background to Family Planning" includes the following birthspacing messages: "Women whose **birthspacing** is **less than three years** endanger themselves and their babies. They do not get enough time to fully recover physiologically to carry another pregnancy in a healthy way and usually the babies are weaned off the breast too early." "Some people may wish to **delay** the birth of their first child, while others may want to **space** the birth of their children." The manual addresses maternal depletion syndrome, which "occurs when mothers become undernourished, often anemic and generally weakened by the burdens of excessive reproduction. The victims of this syndrome become increasingly vulnerable to death during childbirth or to simple infectious diseases at any time. Their babies also swell the infant mortality statistics." Among the benefits of family planning, the manual states that "family planning gives [the mother] a chance to recover from each pregnancy and birth. It reduces the woman's chances of illness or death during pregnancy and childbirth from such causes as hemorrhage, high blood pressure, etc." The manual states that family planning reduces "the risk of back-street abortion or baby-dumping when unwanted pregnancy occurs," and states that family planning allows the mother "to join community activities (e.g., for income generation), thereby improving herself and her family." This section also mentions that family planning also benefits the child because there is "more time for breastfeeding and general care," which reduces the chances of malnutrition. The child has a better chance of receiving loving care, attention and therefore good bonding." The manual states that "high and frequent **parity** increases morbidity and mortality. Mother's **age** has an enormous effect on infant morbidity and mortality, for example, when mothers are too young (i.e., under 18 years) or too old, (i.e., over 35 years of age)." The manual notes that one of the advantages of the natural family planning methods is that "responsibility for **child spacing** is shared by both husband and wife." The manual states that "breastfeeding in the developing world is responsible for more **spacing of pregnancies** than all family planning methods combined." Also presented is detailed information on using the lactational amenorrhea method (LAM) for **child spacing.** It states that "the lactational amenorrhea method is a simple method of **child spacing** that can be easily understood by the mother." In a list of kinds of women for whom the IUD may be appropriate, the manual includes "a woman who already has children and does not want another soon."

Optimal Birthspacing Initiative Desk Review Checklist
Document 10

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
1. The extent to which training materials, protocols, client–provider interaction documents, or other educational and outreach tools/strategy documents contain guidance that can be used by providers, supervisors, and managers to educate clients about the health and other benefits of spacing births three to five years, and the risks for mother and child of shorter intervals		
1.a.i. In training materials for counseling or promoting client–provider interaction, is the subject of the health benefits for women and children derived from optimal birth intervals covered?	✓ Yes No *Does not apply	
1.a.ii. If so, would you consider birthspacing for improved health outcomes to be effectively covered in these materials?	✓ Yes No *Does not apply	
1.b.i. In the tools that are available for providers to use when they counsel clients, is birthspacing for improved health outcomes addressed and present?	✓ Yes No *Does not apply	
1.b.ii. If so, would you consider the birthspacing element to be effectively covered in these tools?	✓ Yes No *Does not apply	
1.c.i. Does training for supervisors and managers typically include birthspacing for health improvement components?	Yes No ✓ *Does not apply	Although the role of supervisors is mentioned in the materials, this manual is designed for trainers to use when conducting training of diverse service providers—health care workers, educators, community workers, and others. Many of the learning activities are also appropriate to use with clients and community members as well as providers. In addition, the approach can be adapted for use with young people.

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
1.c.ii. If so, are these elements effectively incorporated in the training?	Yes No ✓ *Does not apply	Although the role of supervisors is mentioned in the materials, this manual is designed for trainers to use when conducting training of diverse service providers—health care workers, educators, community workers, and others. Many of the learning activities are also appropriate to use with clients and community members as well as providers. In addition, the approach can be adapted for use with young people.
2. How training materials reflect and incorporate the latest research findings on birthspacing		
2.a.i. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to maternal morbidity as well as mortality?	✓ Yes No *Does not apply	
2.a.ii. Of the training material that does cover the health benefits of optimal birth intervals, does the training content include relationships of optimal birth intervals to child morbidity and mortality?	✓ Yes No *Does not apply	
2.b. Does the training material discuss the potential needs of young (i.e., 15 to 24-year-old), low parity (i.e., parity of two or less) women?	✓ Yes No *Does not apply	
2.c.i. Does training content include the concept that some zero parity women are interested in postponing their first birth?	✓ Yes No *Does not apply	
2.c.ii. Does the training content recommend what counseling techniques can be effective for contraceptive choices for the zero parity women?	✓ Yes No *Does not apply	
3.The relative effectiveness or "realism" of existing training approaches in covering birthspacing and optimal birth interval topics relative to improved health outcomes for women and children		
3.a.i. Given the known content and nature of existing training materials, do you think the trainees are currently acquiring sufficient knowledge or skills to articulate the health benefits of optimal birth intervals to clients or staff?	✓ Yes No *Does not apply	

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
3.a.ii. If not, why not?	Why not? ✓ *Does not apply	Answered "yes" to previous question.
3.b.i. In your opinion, is the length of training currently undertaken relevant to health benefits from birthspacing sufficient to enable service providers or program managers to effectively provide optimal birthspacing services (e.g., counseling and provision of a broad range of contraceptive methods in a variety of contexts, such as during prenatal and postpartum care)?	✓ Yes No *Does not apply	This is a 4–day sample training model that can be adapted, depending on the needs of the participants to be trained and the reality of the clients and community members they serve.
3.b.ii. If not, why not?	Why not? ✓ *Does not apply	Answered "yes" to previous question.
4. Existing technical approaches for implementing the existing knowledge and best practices at the service delivery level		
4a. Do current training materials and/or approaches provide sufficient tools or methodologies for providers or program managers to practically improve services for birthspacing, particularly for young (i.e., 15 to 24-year-old), low parity (parity of two or less) women?	✓ Yes No *Does not apply	
4b. If not, why not?	Why not? ✓ *Does not apply	Answered "yes" to previous question.

Part I. Training Questions for Current Training Materials and Other Tools		
Training Questions	**Response**	**Comments**
4c. What would you recommend to strengthen the coverage of practical birthspacing service delivery in training? 4.c. Recommendations: In chapter 6, *Interpersonal Communication: Talking With My Partner*, a birthspacing role play could be added to the sample role plays used by participants to identify nonverbal messages; among the participant practice exercises for situations that are difficult for women and men to talk about, an optimal birthspacing situation could be added; a sample optimal birthspacing negotiation role play could be added to the partner negotiation role plays; optimal birthspacing assertive communication skills could be added to the list of topics to address; an optimal birthspacing role play could be added to the sample role plays for communicating about self-care practices. In chapter 7: *Interpersonal Communication: Skills for Providers*, optimal birthspacing could be included in the list of specific topics in which providers need to increase their competency and update their knowledge and skills; an optimal birthspacing role play could be added to the sample trainer role plays on listening, observing, and responding; optimal birthspacing posters could be added as an example of a memory aid; a sample optimal birthspacing role play about a client who wants to space her births could be added to the sample counseling, communication skills, and reproductive health awareness (RHA) role plays; the GATHER Guide to Checking Your Counseling Skills could add optimal birthspacing information when the provider helps the client think about how different choices may affect his or her life. In chapter 8: *RHA Through the Life Cycle: Birth Through Adolescence*, the activity that has young people draw a time line for planning their major life accomplishments, consideration for including a three to five–year gap between births could be included. In chapter 9: *RHA Through the Life Cycle: Fertile and Aging Adults*, the topic of optimal birthspacing could be addressed by adding another question about birthspacing in the sample scenario for working with adults (under the section on gender) that deals with a young woman who has been married less than a year. In chapter 10: *Family Planning and the RHA Approach*, among the list of potential topics for inclusion, add optimal birthspacing as a topic. Also in chapter 10, consider adding information about the health benefits of birthspacing to step 4 in the sample checklist for male condom instruction, in which the provider tells the client the health benefits of family planning. In chapter 11: *Creating Change: Achieving Healthy Behaviors*, where examples of ways providers can help clients are given, consider adding the benefits of birthspacing to the bullet "Reduce unintended pregnancies by ensuring informed choice and raising awareness of the benefits of consistent family planning method use." Also in chapter 11, consider adding birthspacing as a health goal among the potential health goals mentioned. In the sample lesson plan for session 11—when participants learn about the stages of change model and analyze various client situations to determine the client's stage of change—consider adding a client situation or case study in which the client needs to change the negative health behavior of having children who are spaced too close together or use optimal birthspacing as a reproductive health example that participants use to apply the stages of change model. And, in chapter 11, consider including the concept of optimal birthspacing in sample case number 3, when participants consider the following questions regarding counseling a multiparous, anemic, weak, tired, and unhappy-to-be pregnant woman: "Regarding her readiness to use family planning, where in the Stage of Change Model is she most likely to be now? and "After the birth of the baby do you think she will be in the same stage of readiness regarding the use of family planning? Why or why not?" Also in chapter 11, consider using sample case number 6—in which a newly married woman is "very afraid of becoming pregnant" because she feels having a child would prevent her from achieving some of her personal lifetime goals and her husband is not in agreement with her life goals—to address the specific needs of a postadolescent, zero parity woman who wants to postpone the birth of her first child. Chapter 13: *Implementing the RHA Approach* includes suggestions for integrating the RHA approach in counseling protocols, surveys, focus groups, and interviews. Optimal birthspacing could be integrated in the same way as part of this curriculum. Chapter 13 gives sample learning objectives; a sample optimal birthspacing objective could be added. Chapter 13 gives a sample list of ways to incorporate a RHA approach; this list includes "Develop, post, and distribute materials that promote health behaviors like hand washing, prenatal care, dental care, immunizations, and testing for sexually transmitted infections"; consider adding optimal birthspacing to this statement as an example of a health behavior that can be promoted by means of educational materials for clients and communities. Chapter 13 also suggests using "quality educational materials in an effective way" to "reinforce key messages and help people learn and remember important educational points"; consider suggesting the development of posters and other educational materials that convey the key message, "3 to 5 Saves Lives." In chapter 14: *Evaluation: Trainer, Participants, Training, and Program*, add questions (to the sample pretests and posttests) that determine whether participants understand the concept of optimal birthspacing; in the evaluation game, *Our Bodies, Our Lives,* consider adding an optimal birthspacing question and answer.		

Part II. Document Summary (all team members contribute to this section)

5a. Document number: 10

5b. Citation, including number of pages: [Citation removed for confidentiality.]

5c. Overall content: The manual comprises 14 chapters, which focus on reproductive health awareness, including awareness of the human body and the many opportunities for self-care; gender issues that affect reproductive health and efforts to address gender inequities; a person's own sexuality as well as the sexuality of others; and the power of interpersonal communication for improved reproductive health. These points reflect the four key components of the reproductive health awareness approach—body awareness and self-care, gender, sexuality, and interpersonal communication.

5d. Overall purpose of document and countries of use: This resource manual is designed for training providers to develop reproductive health classes and training programs. The ultimate goals of such training programs are to increase knowledge, foster supportive attitudes, and develop skills that are important for good reproductive health for people of all ages. The manual can be used in developing countries as well as other nations. The manual has been developed, published, and used in a variety of projects to train staff and partners on important reproductive health issues.

5e. Summary of birthspacing information included in document: Birthspacing messages were included throughout this curriculum.

APPENDIX E

BIRTHSPACING MESSAGES CONTAINED IN TRAINING MATERIALS

BIRTHSPACING MESSAGES CONTAINED IN TRAINING MATERIALS

Two training documents from the cooperating agencies' birthspacing materials (numbered 3 and 10) contained messages that are provided below as samples of how subjects are covered in training.

DOCUMENT 3

In describing Afghanistan's national health policy, this document lists among several mechanisms for achieving national family planning (FP) goals the statements that "couples will be provided with . . . a wider range of birthspacing methods. . . ." and "an information, education, and communication campaign emphasizing child spacing, safe motherhood, and women's health will be carried out." Afghanistan's "safe motherhood strategy includes birthspacing as an important element of services. Among the three objectives that the FP strategy focuses on is "strengthening information, education, and behavior change communication for FP birthspacing." Among the three strategic approaches for achieving the FP objectives is "involvement of community, civil society organizations, and community and religious leaders for promoting birthspacing."

The chapter on "Family Planning and Its Role in National Development Goals" includes extensive birthspacing information.

High Fertility and Its Impact on Mothers and Children

The reasons for high fertility are early pregnancies (among adolescents), closely spaced births, and too many pregnancies. The impact of these is described below.

<u>Problems Related to Early Childbearing (Among Adolescents Less Than 18 Years)</u>

- Because the adolescent is still growing, pregnancy affects the growth of both the girl and the fetus because of competing demands for nutrients between the adolescent and the fetus.
- A young girl who starts her family early may become pregnant more often, thus increasing her risk of morbidity and mortality due to high parity.
- Some life-threatening problems of pregnancy are more common among young girls who are pregnant.
- Pregnancy worsens existing anemia, which is already common in many young girls.
    - An anemic mother may give birth to an anemic child.
    - An anemic mother is more at risk from bleeding during childbirth.
    - Babies born to very anemic mothers may be low birth weight and are at high risk of illness and death.

- A young girl

  - is at high risk of developing complications, injury to the genital tract (e.g., obstetric fistula), and death during childbirth;

  - may be too emotionally immature to take care of children; and

  - is at risk of contracting sexually transmitted infections (STIs) at an early age due to early exposure to sexual activity.

Problems Related to Pregnancies at Close Intervals

- The risk of dying among newborns and infants born at close birth intervals is high. Other children under 5 are also at increased risk of dying.

- The chances of giving birth to low birth weight babies are high when pregnancies are closely spaced. Low birth weight babies are at high risk of frequent illness or death.

- Anemia is common among mothers with closely spaced pregnancies as the body does not have adequate time to replenish the nutrients lost during pregnancy and childbirth. An anemic mother tires easily and is at risk of frequent illness, which usually affects the health of her children.

Problems Related to Too Many Pregnancies

- The risk of maternal death during labor and childbirth, due to bleeding and prolonged labor, is increased.

- The risk of abnormal presentation of the baby, leading to prolonged labor, is increased. Prolonged labor increases the risk of death and disability of the baby.

- The mother becomes severely anemic due to blood loss during multiple pregnancies. Severe anemia increases the risk of bleeding and heart failure during childbirth.

- Frequent exposure to infections during childbirth increases the risk of reproductive tract infections.

- Babies born to high parity mothers are at risk of being low birth weight. Such babies are at high risk of frequent illness or death.

- The prevalence of malnutrition among children under five, in families with too many children, is high.

Adolescent pregnancy, closely spaced pregnancies, and too many pregnancies are leading causes of maternal and child death.

Family Planning and Its Benefits

How Family Planning Saves the Lives of Mothers and Children

- FP improves survival of mothers and children by helping women to have children at the right age at the right interval, and by limiting the number of pregnancies.

- FP decreases the risk of death of children by ensuring the survival of their mothers. The increased risk of death of children of mothers who die is well documented.

> Family planning saves lives by reducing the risk of death related to "the four toos": too young, too old, too many, and too close together.

How FP Improves the Health of Mothers and Children

Family planning helps to

- delay the first pregnancy until 18 years of age, thus
  - helping young girls attain their full growth potential, and
  - reducing the risk of injury and infection of reproductive organs, which are not yet fully developed;
- space pregnancies adequately, thus
  - providing the mother with enough time to replenish the nutrients lost during pregnancy and childbirth, reducing the risk of anemia and infections;
  - allowing more time for the mother to take care of the youngest baby; and
  - reducing the risk of death among children; and
- limit the number of pregnancies, thus
  - reducing the risk of maternal death,
  - preventing severe anemia in mothers, and
  - improving the chances of survival of infants and children under 5 by reducing the risk of low birth weight and malnutrition.

Family Planning and Women's Empowerment

Family planning is a basic human right of a woman that has been violated in many communities across the country. Every woman has the right to make a choice about her reproduction.

- Family planning helps a woman to plan her family, which may be the first decision she has made about her own life. This decision gives her self-confidence and encourages her to make other decisions in her life.

- Planning her family increases a woman's opportunities for employment outside the home, which in turn widens her access to information. Repeated pregnancies and childbirth limit employment opportunities.

- Planning her family provides opportunities for continued learning and education, which contributes to empowerment.

- The ability to make decisions and the increased capacity to earn through employment will gradually empower a woman.

- Family planning helps a woman to improve her role as caretaker of the family. With fewer pregnancies, the woman will have more time to devote to the needs of her family and society.

In its "Overview of Family Planning Methods," this document lists condoms, oral and injectable contraceptives, and IUDs (methods currently available in Afghanistan) as modern methods "for spacing births."

In chapters on specific contraceptive methods, the document includes the following birthspacing messages:

- "Injectable contraceptives are appropriate for any woman who wants a long-term birthspacing method or has completed her family, but is not ready for a permanent method."

- "Copper T380A is one of the most cost-effective spacing methods with an effectiveness of 99.2 percent." "The IUD is appropriate for any woman in the reproductive age group, who has borne a child and who wants to space or prevent pregnancy."

- The Postpartum Contraception appendix includes the following birthspacing message: "Many postpartum women want no more children or would like to delay pregnancy for at least two years."

- The Postabortion Contraception appendix includes the following birthspacing message: "At a minimum, all women receiving postabortion care need counseling and information to ensure they understand they can become pregnant again before the next menses, there are safe contraceptive methods to prevent or delay pregnancy, and where and how they can obtain FP services and methods."

- The "Contraception for People Under 18" appendix includes the following birthspacing message: "early childbearing . . . is associated with poor health in both young mothers and their infants."

DOCUMENT 10

The opening chapter includes birthspacing as part of its description of Reproductive Health Awareness (RHA) as it applies to the life cycle from birth until death: "[RHA] provides adolescents and adults with the information and skills to empower them to actively shape their own reproductive health destiny in a manner which brings self-esteem, **satisfaction with timing and spacing of children if desired**…" Chapter 1 also includes **when** to have children in a list of basic reproductive rights.

Chapter 4, *Body Awareness and Self-Care Practices*, includes "Planning the number and **spacing** of our children" in a list of self-care practices for good reproductive health. This chapter also includes "**spacing births** at least two years apart to improve the health of the mother and her children" as a reproductive health prevention practice in a section on self-care fundamentals. This chapter also includes the following birthspacing messages in a list of potential self-care practices for improved reproductive health: "Wait to begin having sex (or to get married) until you are older." "To plan the number and **spacing of children**, be sure you and your partner understand your fertility and use the family planning method that is right for you both." "Postpone the birth of your first child."

An activity that intends to dispel myths regarding male sexual functioning in chapter 5, *Sexuality: Healthy Expression Throughout Life*, examines the following myths, among others: "The woman should become pregnant soon after marriage," and "Women need to marry and bear children early."

In chapter 6, *Interpersonal Communication: Talking With My Partner*, during the discussion about assertive communication, participants are asked to consider the decision to **space children** among other attitudes and beliefs that help a young person advocate for his or her own reproductive health. In an activity that provides practice for changing negative statements to "I" statements for more effective communication between partners, the statement "You don't care about my needs or how I feel about having another child" is included.

Chapter 8, *RHA Through the Life Cycle: Birth Through Adolescence*, includes "benefits of delaying the age of marriage and the birth of your first child" among sample RHA themes for youth (under sexuality). This chapter refers to a study that found that "delayed sexual activity among girls" was an indication of high self-esteem; this chapter mentions that married adolescents (not just unmarried adolescents) face "the health risks of early pregnancy."

Chapter 9, *RHA Through the Life Cycle: Fertile and Aging Adults*, includes among sample RHA themes for adults (under sexuality), "**risks and consequences of pregnancies spaced less than three years apart**," and pregnancies at a "very young" age.

Chapter 10, *Family Planning and the RHA Approach*, includes planning **when** they would like to have children as one of the ways people can use family planning.

Chapter 10 also includes the following benefits of family planning.

Benefits of Family Planning

Regardless of the method used, family planning can help women, men, and even their children live **healthier** and more fulfilling lives.

Family planning can help women and men

- **delay** the birth of their first child until they are emotionally and financially ready to have a child;
- have the number of children they can care for and afford to clothe, feed, and educate;
- use their time and resources to do things besides child rearing, such as going to school, getting a job, or preparing the home;
- express their sexuality without fear of pregnancy; and
- protect themselves from HIV/AIDS and other STIs (if using condoms correctly or abstaining from penetrative sex).

Family planning can also help women

- **keep healthy after childbirth by having time to recuperate from one pregnancy before becoming pregnant with another child,**
- **avoid potential health risks of pregnancy, and**
- **space children at least three years apart for optimal health and survival of themselves and their children.**

When parents plan their families, their children are often able to

- **breastfeed for two years or more, before another child is conceived who also will need to nurse;**
- enjoy more opportunities for getting enough food, clothing, education, and loving attention from parents; and
- grow up with more opportunities for good health and family resources.

Chapter 10 includes the following definition of family planning: "The freedom and ability to decide whether to have children, how many to have, and **when to have them**. The different ways to limit or **space births** are called 'family planning methods.'" The definition for reproductive options includes an individual's and couple's option to choose "to limit or **space** the number of children they have in a **safe** and comfortable way. This chapter includes as one of the gender issues that might influence a person's ability to use condoms effectively, "who decides whether to have a child **soon**." One of the chapter wrap-ups includes the following point, among others, "Our overall reproductive health benefits in very important ways when we plan the number and **spacing of our children**…"

A wrap-up session in chapter 11, *Creating Change: Achieving Healthy Behaviors*, includes "delaying the onset of sexual intercourse in young people" as an example of a positive behavior change. In chapter 11, in sample case study 6, a newly married woman is "very afraid of becoming pregnant" because she feels having a child would prevent her from achieving some of

her personal lifetime goals and her husband is not in agreement with her life goals. This case study provides an opportunity to address the specific counseling needs of a postadolescent, zero parity woman who wants to postpone the birth of her first child.

Also in chapter 11, sample role play 1, *Client Ownership of Behavior Change Decisions*, portrays a recently married woman who would like to postpone the birth of her first child and is not sure what family planning method she would like to use. This role play provides an excellent opportunity for participants to practice providing birthspacing counseling for a postadolescent, zero parity woman. It provides a forum in which participants can experience both the counselor and the client perspectives about the concept of optimal birthspacing for zero parity women.

Chapter 12, *RHA and the Community: A Focus on Safe Motherhood*, includes the following birthspacing message: "Birth to a very young mother, older mother, or a mother who is sickly can put both the mother and her child at greater risk for sickness and death. **When children are born close together in age (less than three years apart), there is a greater physical drain on the mother, and her young children have less chance for good health and survival**."

Chapter 12 includes the following definition of family planning: "The freedom and ability to decide whether to have children, how many to have, and **when to have them**. The different ways to limit or **space** births are family planning methods. **When children are born at least three years apart it is optimal for the health and survival of the mother and her young children**." The definition for reproductive health includes the capability and freedom to decide **when** to reproduce.

Chapter 12 includes sample case study 2, *Family Planning*, which describes a 26-year-old mother of six, who married at the age of 17 and "always became pregnant very quickly after the birth of each child." Participants are asked to consider, among other things, what the health implications are—for the woman, her babies, her relationship with her husband, and her village—of having many babies close together.

Under sample discussion topics listed in chapter 12, in the category of family planning and pregnancy, the following birthspacing topics are included:

- **increased risks associated with having babies too closely together;**
- **ideal birthspacing of 36 months or more to avoid increased risk of premature births, increased miscarriages, maternal anemia, birth asphyxia, and other problems associated with premature births (birthspacing can lessen the impact of pregnancy on breastfeeding—its impact on sexuality [libido, lubrication, time to relate to partner], energy, the food budget, money for education, and all other economic scarcities); and**
- **need for two years between pregnancies to replenish iron stores and three years to improve newborn survival.**

Chapter 14, *Evaluation: Trainer, Participants, Training, and Program*, includes a Fertility Awareness Community Education Session: Skills Checklist. Step 17 of this checklist refers to NFP for **child spacing** or achieving pregnancy.

A chart in chapter 14 that gives sample measures of *Body Awareness and Self Care* includes the following as a measure of attitude in fertile adult females and males: "Is empowered to make thoughtful decisions with partner regarding the **timing** and number of pregnancies and sexual expression."

APPENDIX F

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APPENDIX G

BOLIVIA CASE STUDY

ACRONYMS

BCC	Behavior change communication
CIES	Centro de Investigación, Educación y Servicios (Center for Investigation, Education and Services)
DHS	Demographic and Health Survey
ENDSA	Encuesta Nacional de Demografía y Salud (National Health and Demographic Survey)
FCI	Family Care International
FHI	Family Health International
IEC	Information, education, and communication
IUD	Intrauterine device
LAM	Lactational amenorrhea method
MCH	Maternal and child health
NGO	Nongovernmental organization
POPTECH	Population Technical Assistance Project
PROCOSI	Programa de Coordinación en Salud Integral (Collaborative Program for Integrated Health)
PROSIN	Proyecto de Salud Integral (Integrated Health Project)
PVO	Private voluntary organization
RH	Reproductive health
SUMI	Ley de Seguro Universal Materno Infantil (Law for Universal Maternal and Infant Safety)
USAID	United States Agency for International Development

CONTENTS

EXECUTIVE SUMMARY

As indicated in the scope of work for this global birthspacing programmatic review, "new research, more methodologically rigorous than previous studies, underscores the critical role of child spacing in maternal and child health and nutrition. Important new findings include the following.

- Birth intervals of 24 months are still associated with a 26 percent increased risk of death for newborns, compared with 36–month intervals.[1]

- Extremely short birth intervals—less than 15 months—are associated with a 150 percent increased risk of maternal death as well as related health complications.[2]

- Birth intervals of 20 months or less are associated with increased risk of preterm delivery, fetal death, low birth weight, early neonatal death, and a low Apgar score.[3]

- Even after taking breastfeeding into account, children born at less than three year intervals are at greater risk of dying, compared with children born at three to five–year intervals.[4]

USAID/Bolivia, aware that the issue of birthspacing is particularly important in Bolivia due to the high maternal and neonatal mortality in the country, requested that the team develop a case study on birthspacing in Bolivia that would specifically serve the needs of the Bolivian maternal/child health program. The 1998 Encuesta Nacional de Demografía y Salud (ENDSA 1998) reported national maternal mortality to be 390 per 100,000 live births and neonatal mortality to be 34 per 1,000. Although these figures are high, mortality among subgroups is considerably higher.

In the last 15 years, Bolivia has made great progress in the development of maternal/reproductive and sexual health services. Contraceptive services are legal and the national program insists that women and men of all ages and marital status have the **right to decide** on the use of contraception. This progress is due to the sustained efforts of many people in the public, private, and nongovernmental organization (NGO) sectors as well as donor communities who worked to improve women's health in Bolivia. Their accomplishments are major, considering that 20 years ago the term family planning was taboo.

Challenges continue, however. In terms of mortality, knowledge about contraception, use of contraception, and birthspacing, there remain major differences in Bolivia between adolescents and older women, between rural and urban women, and between women with little or no formal education and those with considerable education. More often, the adolescent girls, rural women,

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[1] Rutstein, Shea, *Effects of Birth Interval on Mortality and Health: Multivariate Cross-Country Analysis*, ORC Macro, Presentation at USAID, July 2000.

[2] Conde-Agudelo, A. and Belizan, J.M., Maternal Morbidity and Mortality Associated With Interpregnancy Interval: Cross-sectional Study, *British Medical Journal*: 321 (7271): 1255–1259, November 18, 2000.

[3] Special analysis prepared by A. Conde-Agudelo and presented in Setty-Venugopal, V. and Upadhyay, U.D. *Birth Spacing: Three to Five Saves Lives,* Population Reports, Series L, No. 13, Baltimore, Johns Hopkins Bloomberg School of Public Health, Population Information Program, Summer 2002.

[4] Rutstein, 2000.

and women with little formal education are among those who are not spacing their pregnancies and who are accordingly, with their infants, dying at higher rates than older, more privileged, urban women. For example, ENDSA 1998 indicates that 11.7 percent of Bolivian women have birth intervals less than 18 months. However, for adolescents, the percentage is 31.8 percent. Among women with such short intervals, the neonatal mortality rate is 89 per 1,000 live births, the infant mortality rate is 170 per 1,000, and under–5 mortality is 211 per 1,000.

The current philosophy under which information and services about contraception are offered is one of human rights (i.e., the right to decide). Fifteen years ago, when the professional community joined forces to combat maternal mortality and recognized that abortion and the lack of contraception were important contributing factors in that mortality, the programmatic focus was reproductive risk. This case study recommends that the concept of reproductive risk, specifically the correlation between spacing and health benefits for mother and child, be reintroduced. Women and men have the **right to know the risks** for mother and child of too closely spaced pregnancies. Considering that this is an issue of saving lives, women and men also have the **right to know about the relative user effectiveness** of various methods of spacing pregnancies as well as the **right to affordable, effective contraception**.

Numerous studies, which are cited in this case study, discuss barriers to these rights. There have been no national information, education, and communication (IEC) or behavior change communication (BCC) activities on reproductive risk or birthspacing for more than 10 years. Many women and men state that they do not understand contraception, have fears about modern methods, and do not understand mechanisms for spacing based upon abstinence during the menstrual cycle. Many indicate male opposition to modern methods based upon machismo. Men and women acknowledge that often the use of rhythm and fixed days methods is ineffective because of lack of male support, including domestic and sexual violence. Moreover, in many rural areas there is a shortage of oral contraceptives, condoms, intrauterine devices (IUDs), and Depo-Provera® in public sector facilities.

This case study contains seven recommendations to enable women and men to space pregnancies effectively.

1. Enlarge the rights concept to include the right to health.

2. Hold a workshop and bring together all the key stakeholders to develop consensus and plan for next steps in the national program on birthspacing, “3 to 5 saves lives.”

3. Hold a workshop with key stakeholders to develop a plan to address, specifically, the barriers that rural, adolescent, and less formally educated women face in terms of knowledge and effective means to space pregnancies.

4. Review materials from the Law for Universal Maternal and Infant Safety (SUMI) on orientation on contraception and differentiate between theoretical effectiveness of spacing methods and user effectiveness of such methods.

5. In light of the prevailing abortion rates in Bolivia, focus on spacing pregnancies rather than births.

6. Integrate birthspacing messages (spacing pregnancies three to five years saves lives) into prenatal care, delivery, postnatal care, and treatment of hemorrhage during the first half of pregnancy services of the national program on a routine basis.

7. Continue work on gender, women's empowerment, and educational processes with men on sexual and reproductive health.

I. INTRODUCTION AND BACKGROUND

BIRTHSPACING INTERVALS

New birthspacing research shows that three to five–year intervals save more lives than two-year intervals or less.[5]

INFANT MORTALITY

Compared with 36 to 41–month birth intervals, 24 to 29–month intervals are associated with an elevated risk of death:

- 26 percent: neonatal deaths,
- 43 percent: infant deaths, and
- 51 percent: under–5 deaths.

With respect to neonatal/infant mortality, risks increase after 60 months. With respect to perinatal mortality, risks increase after 42 months. The best evidence indicates that three to five–year intervals are associated with the lowest risk of death among children.

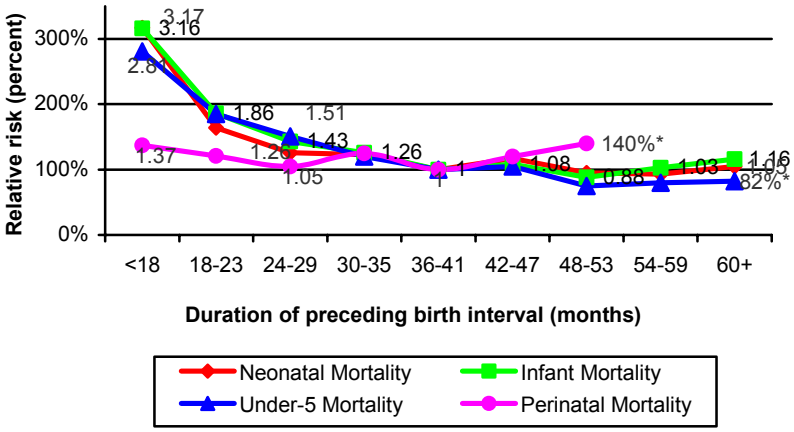
NUTRITIONAL STATUS

Longer birth intervals are associated with nutritional status improvements. Compared with 36 to 41–month intervals, 24 to 29–month intervals are associated with a

- 28 percent elevated risk of stunting, and a
- 29 percent elevated risk of being underweight.

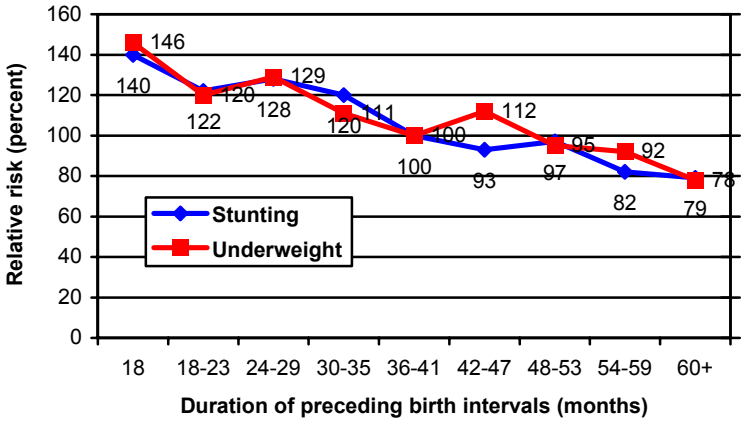
Birth intervals longer than 41 months are associated with additional improvements in nutritional outcomes. The best evidence indicates that three-year intervals or longer are associated with the lowest risk of adverse nutritional outcomes.

Figure G–1
Risk of Death Among Under–5 Children With a Preceding Birth Interval of 36–41 Months Compared With Risk of Death at Other Birth Intervals^



^ Fifteen confounding factors taken into account

Figure G–2
Three-Year Intervals or Longer are Associated With Lowest Risk of Stunting and Being Underweight Among Under–5 Children



[5] Unless otherwise noted, data for figures G 1–3 are drawn from Rutstein, Shea, *Effects of Birth Interval on Mortality and Health: Multivariate Cross-Country Analysis*, ORC Macro, Presentation at USAID, July 2000. These and other analyses are summarized in Setty-Venugopal, V. and Upadhyay, U.D., *Birth Spacing: Three to Five Saves Lives,* Population Reports, Series L, No. 13, Baltimore, Johns Hopkins Bloomberg School of Public Health, Population Information Program, Summer 2002.

MATERNAL MORTALITY

Birth intervals of 9 to 14 months are associated with an increased risk of

- maternal death (150 percent),
- third trimester bleeding (70 percent),
- premature rupture of membranes (70 percent)
- puerperal endometritis (30 percent), and
- anemia (30 percent),

compared with 27 to 32–month birth intervals. Intervals longer than 69 months are associated with an increased risk of

- preeclampsia (80 percent) and
- eclampsia (80 percent).

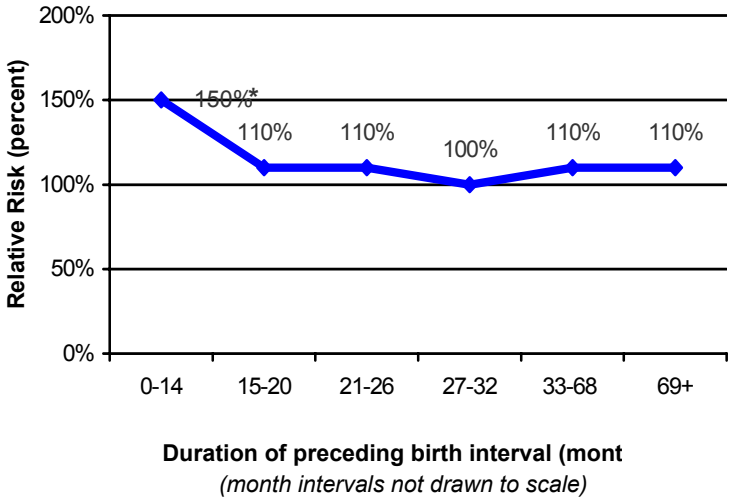
MAGNITUDE OF THE PROBLEM

Demographic and Health Survey (DHS) data confirm that many women desire longer intervals. Yet in most developing countries, more than 50 percent of nonfirst births occur less than 36 months after the previous birth.

In less developed countries (excluding China), if no births occurred before 36 months of a preceding birth, the

- infant mortality rate would drop by 24 percent,
- under–5 mortality rate would drop by 35 percent, and
- deaths of children under 5 years of age would fall by 2,875,000 annually.

Figure G–3
Risk of Maternal Death by Length of Birth Interval^



^ Fifteen confounding factors taken into account
* Difference in risk of pregnancy related death is statistically significant (p<.05)

Source: Conde-Agudelo, A. and J.M. Belizán, "Maternal Morbidity and Mortality Associated with Interpregnancy Interval: Cross-sectional Study," *British Medical Journal,* 321 (7271): 1255–1259, November 18, 2000.
http://bmj.com/cgi/content/full/321/727/1255

Knowledge about the risks of births that are spaced too closely as well as the health, nutritional, and other benefits of longer intervals to help ensure healthy birth outcomes is a basic health right. Many family planning programs, however, focus principally on contraceptive methods and side effects and fail to include information on the benefits and risks of intervals that are too long or too short. Birth interval data indicate that new strategies and program models are needed to reduce the relatively large percentage of too closely spaced births in many countries.

The majority of nonfirst births in developing countries occur after too short an interval. In 55 developing countries, 57 percent of women have spaced nonfirst births shorter than three years and 26 percent have spaced births less than two years apart. In at least five Latin American countries, approximately 95–97 percent of adolescent girls ages 15–19 have birth intervals of less than three years.[6]

In many countries, the percentage of short birth intervals is static or increasing. In many developing countries, the percentage of married women of reproductive age who experience

[6] Setty-Venugopal, V. and Upadhyay, U.D., Summer 2002.

short birth intervals has declined minimally or not at all. For example, over the past 5–10 years in Burkina Faso, Madagascar, Niger, Tanzania, Uganda, Zambia, Nepal, the Philippines, Bolivia, and Yemen, there has been a reduction of only 1–2 percent in women reporting birth intervals under three years.[7]

Women want longer birth intervals, but are not achieving them. Global data show that only 2–3 percent of postpartum women report wanting another birth within two years, yet only 40 percent are using family planning.[8] If women could achieve the birth intervals they want, child mortality would decline. For example, in Kenya, under–5 mortality would drop by 17 percent.

Absence of service delivery guidelines, policies, and protocols. Currently, there are few norms, standard protocols, training materials, or guidelines for birthspacing counseling in developing countries and limited training curricula. USAID–sponsored focus groups conducted in five countries (Bolivia, Peru, India, Pakistan, and Egypt) indicate that clients, providers, and NGOs (which could potentially play an educational and outreach role) often do not understand the relationship between birthspacing and child and maternal survival and nutritional status. Providers indicated that they do not discuss the benefits and risks of long and short birth intervals due to the absence of standard guidance and protocols. Specifically, they understand birthspacing as generally good for health, but lack information on the mortality/morbidity/nutritional risks of short intervals for both mother and child. In addition, it appears that policymakers and program managers have not received adequate information on the potential economic, fertility, nutrition, and health benefits of birthspacing.

BOLIVIAN CASE STUDY

In light of the above data, the USAID Bureau for Global Health, Office of Population and Reproductive Health (GH/PRH) requested a global review and documentation of birthspacing education, counseling, and related components in family planning/reproductive health and child and maternal health programs. This review was to address two broad questions:

- How effectively are programs educating families, providers, and policymakers about birthspacing as a maternal and child health intervention?

- What program improvements are needed?

USAID/Bolivia, aware that the issue of birthspacing is particularly important due to the high maternal and neonatal mortality in the country (the highest on the continent), requested that the POPTECH team contracted by USAID to undertake the programmatic review develop a case study on birthspacing in Bolivia that would specifically serve the needs of the Bolivian maternal and child health program. In response, this case study was developed by one of the POPTECH team members who has worked and consulted in Bolivia in maternal and child health since 1982. She spent a week in La Paz interviewing professionals in maternal and child health (annex A) and reviewed extensive documentation on the subject (annex B).

[7] Ibid.
[8] Ross, J. A. and Winfrey, W., "Contraceptive Use, Intention To Use, and Unmet Need During The Extended Postpartum Period," *International Family Planning Perspectives* 27 (1): 20–27, March 2001.

II. BOLIVIAN ENVIRONMENT

MATERNAL AND INFANT/CHILD HEALTH DATA

Bolivian maternal health indicators over the period from 1989 to 1998 demonstrate positive trends as table G–1 indicates. Higher percentages of women are being attended by trained personnel at delivery, are delivering in hospitals, and are receiving prenatal care. The percentage of women who wish to postpone or limit childbearing but who are not using contraception is less than half the rate of 15 years ago.

Table G–1
Maternal Health Data, 1994–1998 (ENDSA 1998)*

Maternal Health Data	1989	1994	1998
Maternal Mortality for 100,000 Live Births	0	390	0
Deliveries Attended by Trained Personnel (%)	42.5	47.2	59.3
Delivery in Hospital (%)	37.6	42.3	55.9
Prenatal Coverage (%)	44.9	52.5	69.0
Ideal Number of Children	2.6	2.5	2.6
Total Fertility Rate	5.1	4.8	4.2
Contraceptive Prevalence, All Methods	30.3	45.3	48.3
Contraceptive Prevalence, Modern Methods	12.2	17.8	25.2
Married Women of Reproductive Age Who Wish To Postpone or Limit Childbearing but Who Are Not Using Contraception	58.4	24.3	26.1

*The preliminary report from the 2003 DHS was being developed while the case study was being written. It was expected that further progress was being made in the various indicators.

However, the gap between the ideal number of children and the total actual number of children remains great. Women are having almost twice as many children as they would like. The difference between the number of children desired and the actual number achieved is particularly great for rural women and those with little formal education.

Table G–2
Difference Between Desired and Actual Fertility (ENDSA 1998)*

Characteristics	Desired No. of Children	Actual No. of Children
Residence		
Urban	2.2	3.3
Rural	3.2	6.4
Level of Formal Education		
None	3.8	7.1
Basic	3.1	5.8
Intermediate	2.8	4.6
Middle and higher	2.1	2.7
Total 1998	**2.5**	**4.2**
Total 1994	**2.7**	**4.8**

*The preliminary report from the 2003 DHS was being developed while the case study was being written. It was expected that further progress was being made in the various indicators.

Infant and child mortality rates have significantly declined over the period from 1989 to 1998, as table G–3 indicates. Note, however, the great difference between rural and urban neonatal mortality. The rural rate in 1998 is higher than the national average 15 years ago.

Table G–3
Infant and Child Health Mortality, Five-Year Period Preceding Survey
(Deaths per 1,000 Live Births)[9]

Infant and Child Health Mortality	1989	1994	1998
Neonatal Mortality (first month of life)	43	39	34
Urban Neonatal Mortality	30	24	25
Rural Neonatal Mortality	62	57	46
Infant Mortality (first year of life)	91	80	67
Under–5 Mortality	130	107	92

Sixty-one percent of Bolivian nonfirst births occur less than 36 months after the preceding birth. Eighty-two percent of nonfirst births to young women (15–24 years) occur at an interval of less than 36 months.

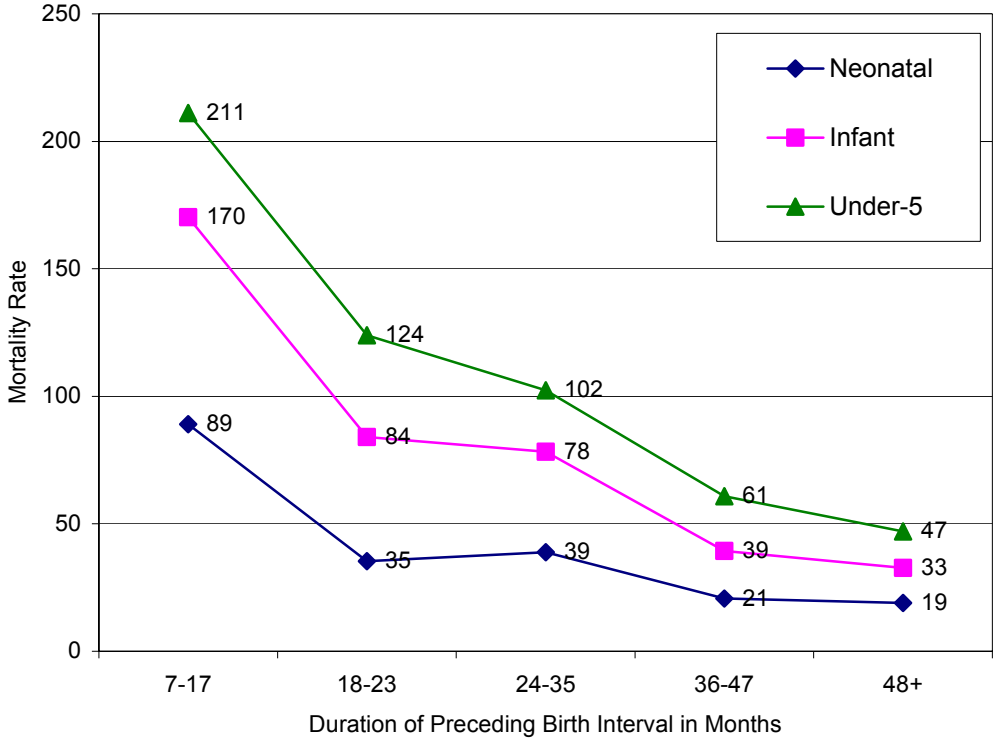
Table G–4
Percent Distribution of Nonfirst Births by Number of Months Since Preceding Birth
(According to Selected Background Characteristics)

Characteristics	Number of Months Since Preceding Birth			
	7–17	18–23	24–35	Total Percent of Births Less Than 36 Months
Age				
15–24	20.9	23.7	37.5	82.1
25–34	11.4	17.9	33.8	63.1
35–49	7.5	10.9	29.7	48.1
Survival of preceding birth				
Living	9.5	16.4	33.9	59.8
Dead	30.6	18.1	26.7	75.4
Education				
No Education	10.2	15.7	35.9	61.8
Primary Education	12.6	17.6	37.7	67.9
Secondary	12.5	16.5	25.8	54.8
More Than Secondary	4.4	10.7	19.2	34.3
Total	**11.7**	**16.6**	**33.1**	**61.4**

ENDSA 1998 presents a clear correlation between short birth intervals and neonatal, infant, and child mortality (see figure G–4).

[9]Consejo Interinstitucional por una Maternidad Segura, *Taller Nacional de Planeamiento Estratégico, Memoria, 3 y 4 de diciembre de 2002.*

Figure G–4
Bolivian Neonatal, Infant, and Child Mortality, Preceding 10 Years by Birth Interval
(ENDSA 1998)



Of particular concern are the adolescents who have the shortest birth intervals (see table G–4 above) and among whom infant and child mortality is higher than women 20–39 years old. In 1998, 14 percent of adolescents surveyed were either mothers or pregnant for the first time. Note in table G–5 that adolescent pregnancy, with its accompanying risks for mother and child, is a problem most acutely for rural teens with little or no formal education.

Table G–5
Percentage of Adolescents (15–19)
Who Are Already Mothers or Who Are Pregnant for the First Time
(ENDSA 1998)

Characteristics	Already Mothers	Pregnant With First Child	Total
Urban	9.2	1.9	11.1
Rural	18.4	3.4	21.8
Level of Formal Education			
None	40.1	11.4	51.5
Basic	28.1	4.5	32.5
Intermediate	16.0	3.0	19.0
Secondary or More	5.2	1.4	6.5
Total 1998	**11.5**	**2.3**	**13.7**
Total 1994	**14.3**	**3.2**	**17.5**

Totals do not always add due to rounding.

REPRODUCTIVE HEALTH POLICY ENVIRONMENT

Before 1989

During the past 15 years, Bolivia has made tremendous progress in meeting the needs of women and couples to space their children. This quite remarkable progress, due to the sustained efforts by USAID, Bolivian NGOs, and public institutions, comes after many years of negative political experiences when there was a total prohibition against all activities related to or mention of family planning.

In 1987, the political environment began to change, partially due to the growing recognition of the magnitude of illegal abortion in the country and the resultant health, social, and economic costs. Between 1975–79, 46 percent of patients in the gynecological services of the Hospital de Clínicas in La Paz were treated for incomplete abortions. In 1987, the Ministry of Health estimated that annually about 40,000 women experienced abortions, of which 20–50 percent might have been induced. Of these women, only about 30 percent reached hospitals for treatment of hemorrhage or infection. Abortion was the number one cause of maternal mortality.

Twelve percent of those who were hospitalized for induced abortions were adolescents (ages 14–19). Eighteen percent had no children (in La Paz, the percentage was 25 percent). Sixty percent of the girls/women were not using contraception; 22.5 percent indicated that they were using abstinence as a method.[10] Interviews at that time with women who had had abortions indicated that 23.4 percent of women had not used a method of contraception because they did not know one. Another 55 percent indicated that the reason was "por descuido" (negligence).[11]

Discussions began as part of an initiative entitled, "La Lucha Contra El Aborto" (Struggle Against Abortion). The use of family planning was recognized as the best means to reduce abortion. At that time,[12]

- unmet need for spacing in the cities of La Paz, El Alto, Cochabamba, and Santa Cruz was 35–36 percent;
- significant percentages of rural women in union did not know any method of family planning: 40 percent in La Paz, 54 percent in Oruro/Potosi, and 53 percent in Chuquisaca;
- total use of contraception was 30 percent, of which 12 percent was modern: in urban areas, total use was 39 percent, of which 18 percent was modern; in rural areas, total use was 19 percent, of which 5 percent was modern;
- 40–60 percent of adolescent girls had sexual relations before they were 17: 28 percent of 19 year olds were mothers; of these, 56 percent had their first child when they were 15–17 years old; and

[10]Ministerio de Previsión Social y Salud Pública*, Seminario Taller Lucha Contra El Aborto*, La Paz, Bolivia, March 20–22, 1989, pp. 139–145.
[11] Ibid., p. 66.
[12] Unidad de Política de Población, *Situación de la Planificación Familiar en Bolivia, Resumen Ejecutivo*, Ministerio de Planeamiento y Coordinación, La Paz, Bolivia, 1993.

- among young women ages 15–24, the use of modern methods in the departments of La Paz and Cochabamba was 0 percent, and the use of traditional methods was 15 percent in La Paz and 13 percent in Cochabamba.[13]

1989–1997

In March 1989, through a collaboration between the Directorate of Maternal and Child Health in the Ministry of Social Provision and Public Health and the Bolivian Episcopal Conference, assisted by a very wide range of national institutions, "La Lucha Contra El Aborto" was launched.[14] It evolved into a national program of reproductive health composed of prenatal and postnatal care, attendance of trained health care professionals during delivery, breastfeeding, detection of cervical cancer, prevention of sexually transmitted diseases, and family planning.

A primary focus of this period was the reduction of maternal and perinatal mortality, to be achieved through the strengthening and expansion of services, popular education, and through targeted IEC and BCC activities, within the context of a national plan for attended deliveries and maternal health.

Primary health care included integrated health care services for women of reproductive age: [15]

- reproductive health, based upon a classification of reproductive risk, including "promotion, education, and facilitation of all methods for gestational spacing, according to the need and decision of the user herself"; reproductive risk was defined in terms of age (under 20 and over 35 years), parity (over four deliveries), birthspacing (less than two years apart), and other health problems that could be aggravated by pregnancy;

- prenatal care with a classification of women by obstetric risk that identified women 17 years or younger and intergestational spacing of 18 months or less (as well as other risk factors); and

- attendance of trained health care professionals at delivery to the newborn, postnatal, and breastfeeding, which attention explicitly included "postnatal promotion and education for gestational spacing."

This was the only period (to date) that the Bolivian national program used mass media to promote family planning, birthspacing, or the right to choose the number and timing of ones' children. Valente et al. (1996) described IEC/BCC interventions as promoting reproductive health services through a series of radio and television spots featuring family planning, birthspacing, prenatal and postnatal care, breastfeeding, and abortion prevention messages. The

[13] Unidad de Política de Población, *La Planificación Familiar en Contextos Específicos de Bolivia*, 1989, Vol. 2, Ministerio de Planeamiento y Coordinación, La Paz, Bolivia, 1993.
[14] Ministerio de Previsión Social y Salud Pública*, Seminario Taller Lucha Contra El Aborto*, La Paz, Bolivia, March 20–22, 1989, p. 28.
[15] Dirección Nacional de Salud Materno Infantil, *Plan Nacional de Supervivencia-Desarrollo Infantil y Salud Materna, Resumen Ejecutivo,* Ministerio de Provisión Social y Salud Pública, La Paz, November 1989, p. 30.

intended audience was urban and periurban women and men of middle and lower economic status, ages 18 to 35, in La Paz, El Alto, Santa Cruz, and Cochabamba.[16]

According to a recent report,

> Campaign messages were designed to emphasize preventive reproductive health care, including prenatal visits, postpartum care, and family planning as a way to avoid abortion, and to enable couples to choose when to have children and how many. The concept of reproductive health was framed in terms of the health of the entire family. Messages instructed people where to go for reproductive health services and emphasized personal responsibility in obtaining services for the benefit of the family.[17]

1997 to the Present: The Right To Choose

Following the International Conference on Population and Development in Cairo in 1994 and the 1995 conference in Peking, Bolivia moved to a greater understanding of reproductive health in terms of human rights. The Bolivian Declaration at the Fourth World Conference on Women recognized "reproductive health as a fundamental right of parents and individuals to decide freely and responsibly the number of children and the spacing of pregnancies within a framework of mutual respect and equality of rights for a man and a woman."[18]

Following the Peking conference, Bolivia expanded definitions of reproductive health to include sexual health and realized that violence against women and girls, including sexual violence, was an important factor in women's health. The Programa Nacional de Salud Sexual y Reproductiva 1999–2002 of the Ministerio de Salud y Previsión Social identifies a number of expected results and subresults. Importantly, one result in this plan is "the sexual and reproductive health of the non-pregnant woman is improved through the offering of health care, particularly the reduction of reproductive risk, before conception." Proposed activities to achieve the result included IEC on family planning and identification of municipalities with high unmet need for family planning in order to focus interventions. However, no national IEC/BCC program has been implemented.

The current operations manuals for contraception are the *Manual de Procedimientos Técnicos en Anticoncepción* and *Normas, Reglas y Protocolos en Anticoncepción.*[19,20] Anticoncepción is classified into temporary methods (lactational amenorrhea method [LAM], abstinence, fixed days method, male condom, female condom, vaginal tablets, intrauterine device [IUD], oral contraceptives, and injections) and permanent methods, such as male and female sterilization. These manuals

- state that during orientation, the provider should learn the interval desired between births by the woman or man—**but the manuals do not state anything about**

[16] Valente, Thomas W. et al., *Reproductive Health Is in Your Hands: Impact of the Bolivia National Reproductive Health Program Campaign*, Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs (JHU/CCP), February 1996.
[17] Ibid., p. 7.
[18] Ministerio de Salud y Previsión Social, *Programa Nacional de Salud Sexual y Reproductiva 1999–2002*, Bolivia 1999, p. 20.
[19] Unidad Nacional de Atención a las Personas, *Manual de Procedimientos Técnicos en Anticoncepción*, Ministerio de Salud y Previsión Social, La Paz, Bolivia, 2001.
[20] Unidad Nacional de Atención a las Personas, *Normas, Reglas y Protocolos en Anticoncepción, Norma Boliviana de Salud, NB-MSPS-05-2001*, Ministerio de Salud y Previsión Social, La Paz, Bolivia, 2001.

orienting users about the correlation between birth intervals and the health of the mother and child; and

- list counterindications for IUDs and oral and injectable contraceptives, **but do not present the limitations of traditional methods** (e.g., periodic abstinence, withdrawal), theoretical effectiveness rates for various spacing methods, **but not user effectiveness rates.** For example, the effectiveness rate of rhythm, the most commonly used method in Bolivia, is presented as 93 percent. In contrast, two Bolivian NGO guides present the far more realistic user effectiveness rate of 80 percent.[21]

Many informants for this case study, in discussing various methods used for spacing in Bolivia, quoted the theoretical effectiveness rates of traditional methods. The concept of user effectiveness, which is key to women's spacing births **effectively** particularly in the context of acknowledged high spousal sexual violence, did not seem to be a part of the Bolivian discourse on spacing.

Table G–6 presents user effectiveness data from the Family Care International (FCI) booklet, *Métodos Anticonceptivos Para Cuidarnos Mejor.*

Table G–6
User Effectiveness Rates for Spacing Methods: "Can one become pregnant using this method?[22]

Method	User Effectiveness	FCI Text
LAM	98%	De 100 mujeres que usan el MELA, 2 se embarazan en los primeros 5 meses después del parto.
Rhythm	80%	De 100 mujeres que practican el método del ritmo, 20 se embarazan durante el primer año de uso.
Fixed Days	88%	De 100 mujeres que practican el método de los días fijos, 12 se embarazan durante el primer año de uso.
Male Condom	86%	De 100 hombres que usan el condón masculino, 14 embarazan a su pareja durante el primero año de uso.
Female Condom	79%	De 100 mujeres que usan el condón femenino, 21mujeres se embarazan durante el primer año de uso.
Vaginal Tablets	74%	De 100 mujeres que usan la tableta vaginal, 26 mujeres se embarazan durante el primer año de uso.
Copper T IUD	99%	De 200 mujeres que usan la T de cobre, solamente 1 a 2 mujeres se embarazan durante el primer año de uso.
Oral Contraceptive	92–94%	De 100 mujeres que toman la pildora, 6 a 8 se embarazan durante el primer año de uso.
Injection, Monthly or Trimonthly	99.9%	De 300 mujeres que se hacen poner la inyección, solamente 1 se embaraza durante el primer año de uso.

The focus of the current approach to contraception is human rights. All Bolivians, regardless of gender, age, or marital status, have a right to contraception.[23] Issues of reproductive risk, which were clearly presented 10 years ago, have been dropped from the national program, including

[21] *Saber Para Decidir* and *Métodos Anticonceptivos Para Cuidarnos Mejor.*
[22] FCI/Bolivia, "Métodos Anticonceptivos Para Cuidarnos Mejor," Serie: *¡Cuidate!* No. 5, Family Care International, Inc., 2003.
[23] In Bolivia, the term for contraception is anticoncepción. Bolivia uses this term, rather than family planning, to stress that the use of contraception is a human right irrespective of family status or intentions.

from manuals and guides for public sector providers who might be reaching rural women with relatively little education and for whom maternal and neonatal mortality pose the greatest risk. There is currently no mass media used by programs on the subject.

Perhaps because data demonstrating the correlation between neonatal, infant, and child mortality as well as preceding birth intervals has not been fully integrated into the national discussion on maternal and child health, service providers and opinion leaders continue to be apprehensive about open discussion on modern contraception. Recent work of the CATALYST project, however, has reintroduced the health benefits of birthspacing to mother and child into the policy discussion agenda. Opinion leaders, who formerly knew of the benefits of at least a two-year spacing, have been introduced to the new data on the benefits of three to five–year spacing. One activity, which had a broad reach, was a letter from the former First Lady on Mother's Day 2003 to all health facilities on maternal mortality and the benefits of spacing three to five years.

Ley del Seguro Universal Materno Infantil (SUMI)
(Law for Universal Maternal and Infant Safety)

SUMI provides free health care in the Ministry of Health and in the Social Security system at all levels for

- pregnant women from the point of conception to 6 months postpartum and
- children from birth until 5 years of age.

However, after the 6–month postpartum period, contraceptives are no longer provided free of charge.

III. REPRODUCTIVE HEALTH SERVICES

CONTRACEPTION (FAMILY PLANNING)

Recent research conducted by PROCOSI, the national network of NGOs in integrated health, confirms other data on the lack of knowledge of Bolivian women regarding how to best ensure healthy outcomes for themselves and their children as well as their desire to space their children. The CATALYST–supported PROCOSI baseline study in eight Bolivian cities or departments of pregnant or nursing women who attended prenatal services in PROCOSI's network concluded that there is [24]

- a lack of knowledge about the relationship between short (less than three years) and long (more than five years) intergestational spacing and complications for the mother and newborn;
- a significant difference between the spacing desired and that achieved; and
- an intention to use contraception postpartum, but obstacles include the fear of side effects with modern methods and the opposition of the male partner to such use.

Although the rhythm method remains the most frequently used method in Bolivia, the use of modern methods to space and limit child bearing has doubled over the last 15 years, as table G–7 indicates. Results of the 2004 ENDSA are expected to show a significant increase in the injectable contraceptive. All informants indicated that the injectable contraceptive has had great success in the last few years. It was uniformly described as being acceptable, safe, and discreet. Unfortunately, it has been one of the methods in scarce supply in the public sector in recent months.

Table G–7
Percentage of Women Using Contraception, 1983–1998
(ENDSA 1998)

Contraceptive Methods	ENPM 1983	ENDSA 1989	ENDSA 1994	ENDSA 1998
Modern Methods	9.9	12.2	17.7	25.2
Oral Contraception	2.7	1.9	2.8	3.8
IUD	3.4	4.8	8.1	11.1
Sterilization	2.4	4.4	4.6	6.5
Other, Including Injection	1.4	1.1	2.2	3.8
Traditional Methods	13.7	18.0	27.6	22.2
Rhythm	12.7	16.1	22.0	20.0
Other Traditional	1.0	1.9	5.6	3.1
Total	**23.6**	**30.3**	**45.3**	**48.3**

The case study data also indicated incidences of contraceptive failure and recourse to abortion with unwanted pregnancy. Emergency contraception is available in the private sector, and discussions are underway in the public sector about offering it.

[24] PROCOSI, *Informe Linea de Base, Proyecto de Investigación Operativa "3 a 5 Años Salva Vidas*."

OTHER REPRODUCTIVE HEALTH SERVICES

Prenatal and postnatal visits, delivery, and emergency treatment for hemorrhage during the first half of pregnancy are excellent opportunities to provide information about the health benefits of birthspacing for mothers and children.

Prenatal Care

According to ENDSA 1998, 69 percent of women delivering in the previous three years had received at least one prenatal care visit. Forty-eight percent had four or more clinic visits. Prenatal visits are an excellent time to inform women about the health benefits of child spacing.

A bulletin for clients by the Centro de Investigación, Educación y Servicios (CIES), *Usted Tiene Derecho a Recibir Información Acerca de Salud Materna (You Have the Right To Receive Information on Maternal Health),* addresses prenatal care, delivery, and postnatal care. One line in the 16–page bulletin indicates that women should be informed during their prenatal visits that options exist for contraceptive methods that could be used after delivery, if the woman wishes.

CATALYST/PROCOSI recently developed a brochure, *Embarazo Saludable, Seguro y Feliz (A Healthy, Safe and Happy Pregnancy)* that specifically addresses the benefits of spacing births three to five years apart. NGO members of PROCOSI are distributing it during prenatal care visits; CATALYST scheduled an evaluation of the use of the brochure in March 2004.

It is unclear to what extent other providers orient pregnant women during prenatal care about the health benefits of child spacing.

Delivery

ENDSA 1998 indicates that 60 percent of women deliver in a hospital or are attended by a trained provider.

SUMI protocols for delivery at all three levels (including home delivery) state (under information and orientation for the recently delivered woman) that service providers should inform the mother and other family members of the benefits of child spacing (number of years not specified) and all methods of contraception as well as personal hygiene for the newborn and breastfeeding.[25] The CIES bulletin, S*alud Materna (Maternal Health)* concludes with a discussion about spacing for a minimum of two years before becoming pregnant again. It identifies maternal health—but not child health—as the reason.

Postnatal Care

Although in theory a postnatal visit is an ideal time to discuss birthspacing, relatively few Bolivian women receive postnatal care. ENDSA 1998 did not collect data on this issue, but the Interinstitutional Committee for Safe Motherhood indicates that only 27 percent of women received postnatal care.

[25] "Protocolos para la atención de la embaraza y madre hasta 6 meses después del parto," Taller Nacional de Capacitación para Gerentes de Redes, Cochabamba de 31 de enero a 2 de febrero de 2003.

Treatment of Hemorrhage During the First Half of Pregnancy

As indicated in this case study, illegal abortion is one of the contributors to maternal mortality in Bolivia. In 1999, it was estimated that there were approximately 40,000 to 50,000 abortions annually in Bolivia; one estimate attributed 69 percent of abortions to adolescents 14–19 years old.[26] Many women arrive in hospitals for emergency treatment of complications. Treatment of such complications saves lives and provides opportunities to counsel women about contraception as well as to make referrals for other reproductive health services, as necessary. In 2002, following the global evaluation of USAID's postabortion care program, Bolivia began a program for treatment of hemorrhage during the first half of pregnancy. Pathfinder data for 12 months of 2003 (but incomplete for the month of December) from 22 hospitals in five urban and periurban areas indicate that 9,507 women received treatment for hemorrhage during pregnancy. Of these, 75 percent (7,140) received orientation in family planning; 49 percent chose to leave with a modern method of contraception (Depo-Provera®, condoms, oral contraceptives, or an IUD).[27]

[26] Programa Nacional de Salud Sexual y Reproductiva, 1999–2002, p. 35.
[27] Pathfinder/Bolivia

IV. ISSUES

One of the most revealing questions in the scope of work for this programmatic review seeks to define the most important issues (access, quality, gender, knowledge, logistics/commodities, economic, other) that affect women's ability to achieve the birth intervals they prefer. The scope of work also inquired about relevant, country-specific research on this topic.

In addition to ENDSA, there have been a number of studies that shed light on this subject in Bolivia. Section III referenced the PROCOSI baseline study that highlighted lack of knowledge. Additionally, in 2003, the CATALYST Consortium undertook focus group qualitative research in periurban areas of La Paz and Cochabamba to identify such barriers. Family Health International (FHI) undertook such research from December 1995 to February 1996 in El Alto. The Peruvian-based NGO, Movimiento Manuela Ramos, which has a contract with the Proyecto de Salud Integral (Integrated Health Project) (PROSIN) to provide cooperation and technical assistance to initiate a project of integrated community health with special emphasis on sexual and reproductive health in six rural and periurban regions of Bolivia,[28] has conducted extensive research on gender and sexual and reproductive health in seven regions of Peru, including that of culturally similar Quechua and Aymara areas of Puno, across the lake from Bolivia. All of these studies reached similar conclusions.

TO HAVE A CHILD: NOT AN EXPLICIT DECISION FOR MANY

CATALYST focus groups indicated that the women and men in periurban areas of La Paz and Cochabamba believe that "In reality, pregnancy 'just happens.'" It is not something that the couple consciously talks about, plans for, and acts on accordingly; when pregnancy occurs it must be accepted as destiny or God's will."[29]

The FHI qualitative study undertaken with women of reproductive age (and a smaller group of men) indicated a similar lack of intentionality: a pregnancy is not planned but happens at random because the couple has not discussed how to prevent a pregnancy.[30]

MALE OPPOSITION TO CONTRACEPTION, PARTICULARLY MODERN METHODS

Although ENDSA 1998 indicates that a large majority of husbands/partners approve of family planning, recent qualitative data and interviews for this case study indicate that some men may oppose the use of modern methods, fearing that their use gives women sexual freedom. The previously cited FHI study described that men whose wives used the IUD believed that the women could therefore have extramarital relations and that they had consequently lost control over their wife's sexuality.

The report on the CATALYST focus groups in periurban areas states,

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[28] *Convenio de cooperación entre el Proyecto de Salud Integral (PROSIN) y El Movimiento Manuela Ramos (ReproSalud).*

[29] CATALYST Consortium, *Bolivian Focus Groups on Birth Spacing, Qualitative Study in Bolivia*, June 2003, p. 4.

[30] Family Health International, *Las Mujeres de El Alto Se Descubren a Si Mismas, Informe Final*, febrero de 1997, p. 10.

> Women and health care providers report that a woman's decision to use contraceptives is in many cases considered by their partners as a sign of infidelity or lack of love, and therefore strains the relationship and encourages jealousy and suspicion, which in some cases may even lead to abandonment of the partner.[31]

The Movimiento Manuela Ramos revealed similar findings in a 2002 qualitative study in Peru with men on gender issues and sexual and reproductive health. The report on that work, *Opening Our Eyes,* relates the following:[32]

> Another major reason indicated by men to reject contraceptive methods is the fear of not being able to control women's sexuality. The possibility of getting pregnant is a permanent control to dissuade women from seeking extramarital relations. Family planning, independently of the men's acceptance, causes uncertainty to the men and makes them feel vulnerable to a possible infidelity on the part of their wives….For all the above reasons, the method preferred by most men is the rhythm method, as it does not have side effects, and it makes them feel that they have better control of the woman's sexuality and their reproductive capacity. But, at the same time, many express their insecurity for three main reasons: lack of knowledge about the use of the system, possible irregularity of the woman, and men's own lack of responsibility on failing to respect the woman's fertile days.

Based upon self-assessments with over 3,000 women in four Peruvian regions, including Puno Quechua and Aymara areas, Carmen Yon Leau in *Hablan La Mujeres Andinas*[33] (Andean Women Speak) discusses the possibility of women exercising their reproductive preferences and distinguishes between their wishes and their power to achieve their wishes. The majority of women indicated that they had more children than they wished and that the reason for this was a lack of contraception or method failure; they expressed their lack of knowledge about modern methods and fears about associated side effects. They also expressed social reasons: the opposition of their husbands to contraception, particularly modern methods; their fear or lack of confidence in service providers; and the social sanction of other women.

Hablan La Mujeres Andinas cites women who, although they were taking care of themselves (cuidandose), had more children than they desired because the rhythm method (the most commonly used method) failed because of lack of cooperation on the part of their husbands who pressured them to have intercourse on fertile days or because of confusion over dangerous days, or because of a lack of menstrual regularity.

GENDER AND SEXUAL VIOLENCE

Bolivia has declared, "Domestic violence, conditioned by gender inequalities, constitutes a problem in our society… that has become a public health problem.[34] It is estimated that in Bolivia, between 50–60 percent of women are affected by some sort of domestic violence, particularly physical violence, which often results in death. In 86 percent of the cases, the

[31]Ibid., p. 8.

[32] Movimiento Manuela Ramos, *Opening Our Eyes: A Work Experience With Men on Gender Issues and Sexual and Reproductive Health*, Lima, Peru, August 2003, p. 44.

[33] Movimiento Manuela Ramos, December 2000.

[34]" La violencia intrafamiliar conducionada por desigualdades de genero constituye un problema que se encuentra en nuestra sociedad, produciendo no sólo una afectación de los derechos humanos fundamentals sino también repercusiones en el ámbito del trabajo, la economía familiar y especialmente en la salud; impactando de esta manera en forma negativa en el desarrollo humano. Las muertes y traumatismos, ocurrido por causas violentas vienen aumentando en Bolivia y en la Region de las Americas a pasos alarmantes. La violencia, por el número de victimas y la magnitud de las secuelas que produce, ha aduirido un carácter endémico y se ha convertido en un problema de salud pública necesario de atender." *Salud y Violencia Intrafamiliar, Manual de Normas y Procedimientos para la Atención,* Ministerio de Salud y Deporte, Organización Panamericana de la Salud, Organización Mundial de la Salud, Bolivia, Segunda Edición 2002, Presentación.

aggressor is the man of the house, frequently the husband or partner."[35] Male drunkenness was a precipitating factor in 56 percent of the cases studied in a 1997–98 study of prevalence of domestic violence.[36]

The 1997 FHI study reported that a third of women in union were forced to have sex by their partners when they did not want to, generally when the man was drunk. Women identified men's excessive drinking as their most significant family problem. A majority of women in this study also indicated that they had been physically assaulted (agredidas) by their partner. "For many women, physical and sexual abuse is something which happens during the first years of living together and then diminishes with time." [37]

CATALYST Consortium concluded from its focus groups that "men exert control and impose their will when it comes to sexual relations, regardless of whether or not the woman wants to engage in sexual relations for fear of becoming pregnant."[38]

ACCESS TO MODERN CONTRACEPTIVES IN THE PUBLIC SECTOR

The public and private sectors have both been important in providing information about and services for modern methods. In 1998, each sector provided half of Bolivia's most frequently used modern method, the IUD.

Table G–8
Percentage of Users Obtaining Modern Methods by Source of Supply
(ENDSA 1998)

Sector	Method					
	Pill	IUD	Injection	Condom	Sterilization	Total
Public Sector	19.1	49.6	19.6	8.3	62.7	41.5
Private Sector	79.0	49.5	79.4	78.6	36.6	55.8
Other	1.8	0.4	0.5	6.0	0.4	1.4

Informants described two concerns with public sector provision of modern methods.

1. All informants described widespread shortages and stockouts of all modern methods in public facilities below the central level, particularly in rural areas. The USAID–funded DELIVER project is providing technical assistance to the Ministry of Health at the municipal and central levels, but there are significant challenges with decentralization to ensure access to contraceptives at rural health posts. Although the social marketing program of PROSALUD might be expected to compensate for such shortages among households with some disposable income, those in absolute poverty cannot be expected to purchase contraceptives from pharmacies.

2. SUMI provides free contraception for the first 6 months after delivery; after that period, it is no longer covered by health insurance.

[35] Dora S. Caballero, Consultora Nacional OPS/OMS, *Organización de Redes para la Prevención y Atención de la Violencia Infrafamiliar,* Organización Panamericana de la Salud, Organización Mundial de la Salud, Bolivia, Tercera Edición, 2002, p. 11.
[36] *Lo Que Debemos Saber, Salud y Violencia Infrafamiliar, Manual para Personal de Salud,* Ministerio de Salud y Deporte, Organización Panamericana de la Salud, Organización Mundial de la Salud, Bolivia, Primera Edición 2002, p. 103.
[37] Family Health International, *Las Mujeres de El Alto Se Descubren a Si Mismas,* pp. 10–11.
[38] CATALYST Consortium, *Bolivian Focus Groups on Birth Spacing,* p. 4.

LACK OF KNOWLEDGE ABOUT CONTRACEPTION

ENDSA 1998 indicates that significant percentages of women lack knowledge about contraception. Twenty-seven percent who were not using a method and did not intend to use one stated their reason as "did not know one." "Lack of knowledge" was cited as the most common reason for nonuse. The second most common reason was concern about health problems (21.7 percent). Desire for more children was third (13.7 percent).

Numerous studies indicate that women would like more information than they currently receive about birthspacing. CATALYST focus groups indicate that women and men want information on birthspacing and particularly value information from doctors and other "experienced, knowledgeable people."

V. RECOMMENDATIONS

Research in developing countries indicates that spacing pregnancies three to five years apart has significant health benefits for both the mother and child. This section presents recommendations for the MOH, USAID, NGOs, and other development partners to implement in order to enable Bolivian women to more effectively space their children.

1. Enlarge the human rights focus from the right to decide to include the right to be healthy. Demonstrate to program managers, service providers, and clients the correlation between birthspacing and health benefits for women and children. Make it clear to political leaders and other key stakeholders that those who are subject to greater health risks due to insufficient birthspacing are those who are already the most vulnerable in Bolivian society—adolescents, rural women, less formally educated women, and their children.

    - These vulnerable groups have **the right to know** what older, urban, and more formally educated women already know: spacing births at three to five–year intervals saves lives.

    - Adolescents, rural women, and less formally educated women have **the right to take effective measures** to save their lives and those of their children.

2. Hold a workshop and bring together leaders of the national program, including NGOs and donors.

    - Share data both on the urgency of the problem and birthspacing as a means to reduce mortality.

    - Develop consensus among leaders, NGOs, and donors on next steps.

    - Develop resolution on optimal birthspacing intervals that would lead to policy changes, including concepts of reproductive risk.

    - Develop standardized messages and materials with clear guidance.

    - Develop plans for educating service providers on optimal birthspacing intervals.

3. Hold a workshop with key stakeholders, including NGOs and service providers, on the barriers that rural, adolescent, and less formally educated women face in achieving their desired family size. Examine and develop means to address such issues as

    - lack of information about effective birthspacing and

    - limited access to modern methods of contraception for poor women.

4. Review SUMI materials for orientation on contraception and differentiate between theoretical effectiveness of spacing methods and user effectiveness of such methods. Affirm the right of rural, adolescent, and less formally educated women to full information, which includes rates of user effectiveness.

5. In light of the high abortion rates in Bolivia, focus on spacing pregnancies rather than births.

6. Integrate birthspacing messages (spacing pregnancies three to five years saves lives) into prenatal care, delivery, postnatal care, and treatment of hemorrhage during the first half of pregnancy services of the national program on a routine basis.

7. Continue work on gender, women's empowerment, and educational processes with men on sexual and reproductive health.

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