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 **BASICS**

HEALTHY TIMING AND SPACING OF PREGNANCY

BASICS III

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What is Healthy Timing and Spacing of Pregnancy (HTSP) and why is this technical area important to child health?

Although many developing countries have family planning policies and a range of natural and modern family planning methods are available, the benefits of adequate birth spacing to mothers, children, men, communities and civil society are not sufficiently understood. Fertility rates thus remain high and the *unmet need for birth spacing*¹ in developing countries ranges between 22 and 78 percent. Most of all, a high percentage of women with unmet needs experience unintended pregnancies.

Healthy Timing and Spacing of Pregnancy (HTSP) is an intervention to help women and families make an informed decision about the delay of first pregnancy and the spacing or limiting of subsequent pregnancies to achieve the healthiest outcomes for women, newborns, infants, and children, within the context of free and informed contraceptive choice taking into account fertility intentions and desired family size, as well as the social cultural and religious contexts.²

Healthy timing and spacing of pregnancy (HTSP) programs are designed to improve maternal and child survival by helping woman and families make informed decisions about delaying first-time pregnancy and spacing subsequent pregnancies; all within the context of contraceptive choice. It is essential for these programs to take into account families' fertility intentions and desired family sizes, as well as socio-cultural factors in the environments where they are implemented.

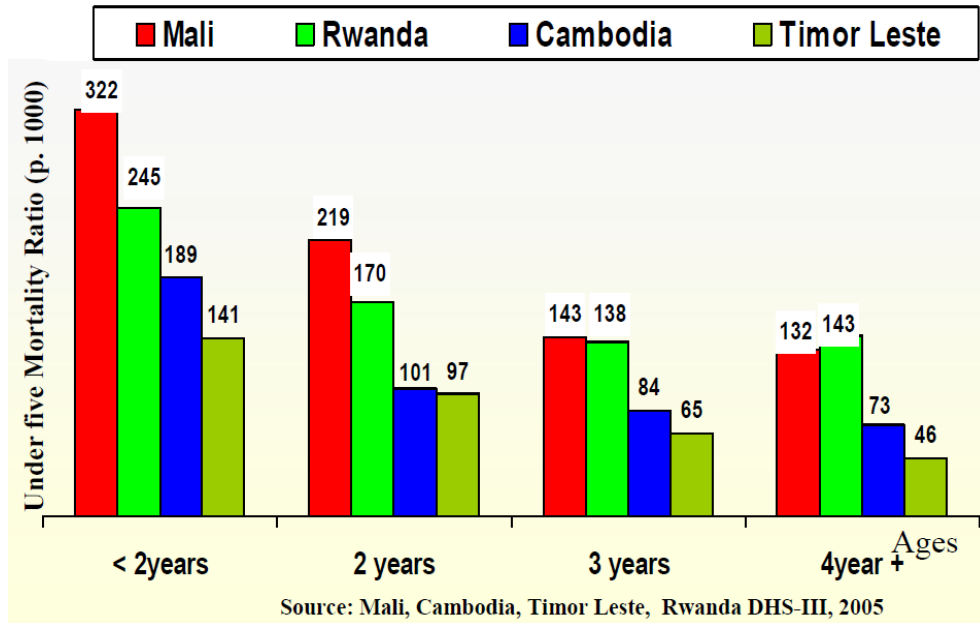
Studies in developing countries have shown that infant mortality can be reduced by up to 24 percent and under-5 mortality by up to 35 percent in families whose children are born at least three years apart (also expressed as an easier-to-calculated gap of at least two years between birth and conception). Similar gains in maternal and child health are made when a woman's first pregnancy occurs after 18 years of age. Moreover, in the particular cases of miscarriage and induced abortions, a space of at least 6 months before new conception has also proven to greatly reduce health risks for newborns and mothers.

Using data from four countries, Figure 1 shows that under-5 mortality decreases as the birth interval increases.

¹ Women not using contraception even though they have stated a preference to space their next birth

² Extended Service Delivery (ESD) Project: Healthy Timing and Spacing of Pregnancy (HTSP). Trainers Reference Manual. Revised August 2008.

Figure 1
Relationship of Under 5 Mortality Rates with Increased Birth Interval Periods, Various Countries



Various country studies have demonstrated the health benefits to mothers and children from greater birth intervals. These are summarized in Table 1.

Table 1
Evidence of Positive health Effects for Children and Mothers of Longer Birth Intervals, Various Studies³

Health Benefits for Children of Greater Birth Intervals	Health Benefits for Mothers of Greater Birth Intervals
<p><i>Lower risk of:</i></p> <ul style="list-style-type: none"> • Child death • Infant death • Neonatal death • Fetal death • Stunting and underweight • Small for gestational age • Low birth weight • Preterm birth 	<p><i>Lower risk of:</i></p> <ul style="list-style-type: none"> • Maternal death • Puerperal endometritis • Premature rupture membranes • Anemia • Third trimester bleeding

What is the HTSP implementation process?

Similar to its work in the area of pediatric HIV and AIDS, USAID/BASICS' HTSP programs emphasized the identification of existing child survival interventions into which HTSP components could be effectively integrated. Thus, in addition to traditional service delivery through family planning clinics, extension to other appropriate health interventions was sought. These points of entry were instances where pregnant women and mothers of infants commonly seeking care including immunization clinics, IMCI clinics, antenatal care, ART/PMTCT, pediatric admissions, nutrition interventions, and postnatal clinics.

At the programmatic level, it was important to consider how HTSP could be integrated within child health policies, including protocols, guidelines, and monitoring and evaluation plans. Ultimately, wherever capacity building of health care workers is being undertaken, an opportunity for integrating HTSP exists; most often mobilizing these workers as IEC providers and sources of referral to family planning services.

³ (1) Conde-Agudelo A., Effect of Birth Spacing on Maternal and Perinatal Health: A Systematic Review and Meta-Analysis. (2) Rutstein, S. Johnson & Conde-Agudelo A. Systematic Literature Review and Meta-Analysis of the Relationship between Interpregnancy or Interbirth Intervals and Infant and Child Mortality. (3) Reports submitted to CATALYST Consortium, October 2004, (4) Conde-Agudelo, A. and Belizan, J.M. Maternal morbidity and mortality associated with interval: Cross sectional study. British Journal (Clinical Research Ed.) 321 (7271): 1255-1259. Nov. 18, 2000.

The implementation process can be expressed by the following table, which includes a column with links to the separate components of the USAID/BASICS HTSP Toolkit used for each step.

Table 2
HTSP Five Implementation Steps and Related key Resources

	IMPLEMENTATION STEPS	KEY RESOURCES
1.	Advocacy Encouraging governments and partners to adoption a strategy, guidelines, or policy for integration of HTSP with key child survival programs.	<ul style="list-style-type: none"> • Advocacy and Capacity Building in HTSP
2.	Integration Developing or strengthening HTSP guidelines and tools, and disseminating them to relevant officials and partners.	<ul style="list-style-type: none"> • Methodological Guide for HTSP Integration at Child Health Service Points
3.	Implementation Training of trainers and on-the-job training of service providers on HTSP integration, including at the central and district levels.	<ul style="list-style-type: none"> • Guide for Rapid Facility HTSP Functionality Assessment • HTSP Field Training Manuals
4.	Supervision, mentoring, and monitoring Maintaining post-training skills through supportive supervision and mentoring.	<ul style="list-style-type: none"> • HTSP Supervisory and Mentorship Checklists • Monitoring and Evaluation Framework for assessing HTSP results at global and country level
5.	Expansion and scale-up Expanding coverage	

USAID/BASICS' Involvement

Added for the first time as a USAID/BASICS technical focus area at the outset of 2005, HTSP activities were conducted in four countries, each with a key accomplishment:

- Malawi—To facilitate integration of HTSP into other child health interventions, raised awareness on the importance of HTSP in relation to the well-being of newborns, children, and mothers.
- Rwanda—Integrated HTSP into the nationwide roll-out of IMCI.
- Swaziland—Integrated quality postnatal care, including HTSP, for postpartum women into PMTCT programs.

- Timor-Leste— Conducted a rapid assessment of family planning services for the integration of HTSP, showing that more than 3,000 child deaths could be averted annually in Timor-Leste if births occurred after minimum intervals of 36 months.

Roll-out example: Rwanda

USAID/BASICS' objective in Rwanda was to introduce HTSP within routine newborn and child health activities by:

- Incorporating HTSP into newborn and child health standards, including Rwanda's post-partum package
- Incorporating HTSP within IMCI, and implementing in selected districts
- Expanding HTSP at facility level and community level

Initiating efforts to achieve these three broad objectives in early 2007, USAID/BASICS combined data from USAID-sponsored studies and the Rwanda DHS with the project's generic advocacy tools (see Table 2), presenting policy makers and child survival program stakeholders with evidence that introducing HTSP into child health services was feasible and would contribute to a significant reduction in childhood deaths. Concluding that HTSP could add considerable value to Rwanda's family planning program, the Minister of Health encouraged USAID/BASICS and its partners to pursue integration with existing and planned programs.

USAID/BASICS subsequently worked with the MOH to integrate HTSP concepts into national policies (e.g., the National Norms and Protocol for Service Delivery), as well as key messages⁴ into programmatic tools (e.g., IMCI guidelines) to be used by implementing partners; primarily USAID's Twubakane and Capacity programs.

By project end, integrated IMCI had been rolled out to 15 of the 30 districts in Rwanda. This includes training of trainers in HTSP integrated care. This notably involved the training of many service providers: a total of 275 health workers and 25 supervisors from 42 health facilities in 15 districts were trained. .

Beyond the all-important inclusion of HTSP in IMCI, USAID/BASICS contributed further to the expansion of HTSP in Rwanda by:

⁴ As noted in the first paragraph of this chapter, the three key HTSP messages are that the health of mothers and children are significantly improved when births occur: (1) at least 24 months after a previous live birth; (2) no earlier than 6 months subsequent to a miscarriage or induced abortion, and; (3) not before a mother has reached the age of 18.

- Collaborating with Rwanda’s immunization program to introduce HTSP messages to mothers as part of counseling received at vaccination service delivery points.
- Integrating HTSP into counseling cards used at the community level.

In 2009, BASICS collected central- and facility-level data, reviewed policies and documents, and conducted interviews with sources at both levels to evaluate achievements in:

1. Integration of HTSP into child health policies, guidelines, curriculum, and other key documents
2. Knowledge of HTSP among women of child-bearing age
3. Capacity-building of service providers through training and supervision
4. Increase in duration of use of a family planning method among new users

The rapid analysis found that in general, the integration of HTSP messages into child health policy was successful, but that the implementation of HTSP in practice at the district level needs improvement.

Click [here](#) to download *Integrating IEC Messages on Vaccination, Birth Spacing, and HIV in Rwanda*.

Click [here](#) to download *Integration of Healthy Timing and Spacing of Pregnancy Within Child Health Services in Rwanda, a Rapid Analysis*.

Results

At the global and cross-country level, there were a number of accomplishments in the development of various tools and structuring of approach to incorporation of HTSP as child health strategy. These are included in the BASICS HTSP Toolkit, the components of which are listed in and can be downloaded from Table 3:

Table 3
BASICS HTSP TOOLKIT
(Click on Titles to download documents)

Tool Kit User Guide
Advocacy Presentations on HTSP <ul style="list-style-type: none"> ▪ What is HTSP? ▪ Support For Advocacy And Capacity Building In Healthy Timing And Spacing Of Pregnancy ▪ Incorporation of Healthy Pregnancy Spacing into Newborn, Infant and Child Health Programs ▪ Operationalization through Integration
Assessment tools <ul style="list-style-type: none"> ▪ Facility Assessment Guide ▪ Exit Interview for Contraceptive Users ▪ Interview with Family Planning Service Providers ▪ Interview with Caretakers ▪ Interview with Health Care Providers ▪ Interview with Men Visiting Health Facilities ▪ Interview with Religious Leaders and Community Workers
Job Aids and Tools <ul style="list-style-type: none"> ▪ Opportunities for the Integration of HTSP into MCH Programs ▪ Messages for use at Immunization sites ▪ Methodological Guide for Effective Integration of Healthy Timing and Spacing of Pregnancy into Newborn and Child Health Activities
Supportive Supervision Checklist for HTSP and Family Planning
Monitoring and Evaluation <ul style="list-style-type: none"> ▪ Core Indicators ▪ Framework for Monitoring and Evaluation ▪ Pre-test of Health Worker Knowledge ▪ Central Level and Partner Interview Guide ▪ HTSP Client Exit Interview ▪ Health Facility Interview Guide ▪ USAID Mission Interview Guide
Training Manual for Integration of HTSP into MCH programs

Some of the key results of HTSP from various countries are summarized in Figures 2 and 3.

Figure 2
Results of HTSP Integration within Maternal and Child Health Services in Rwanda

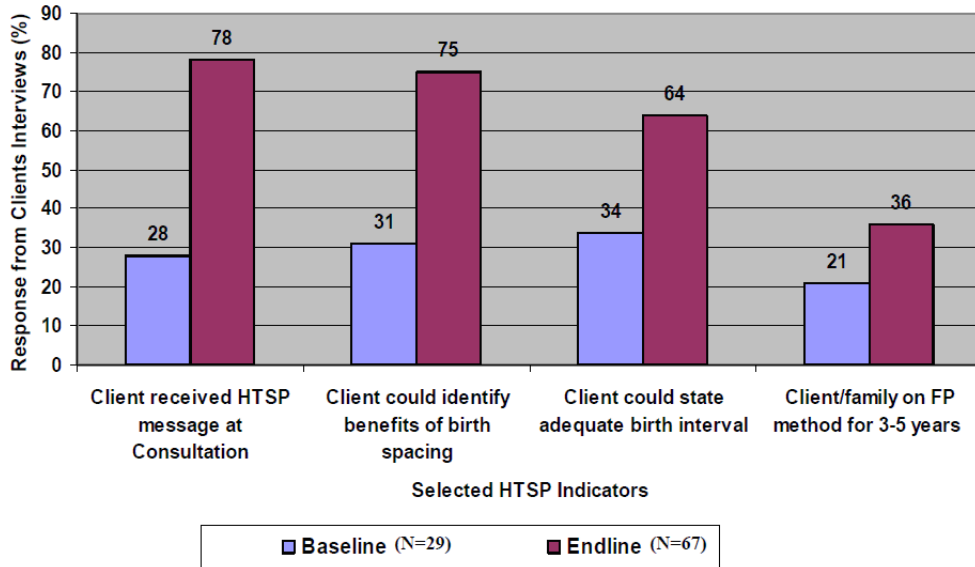
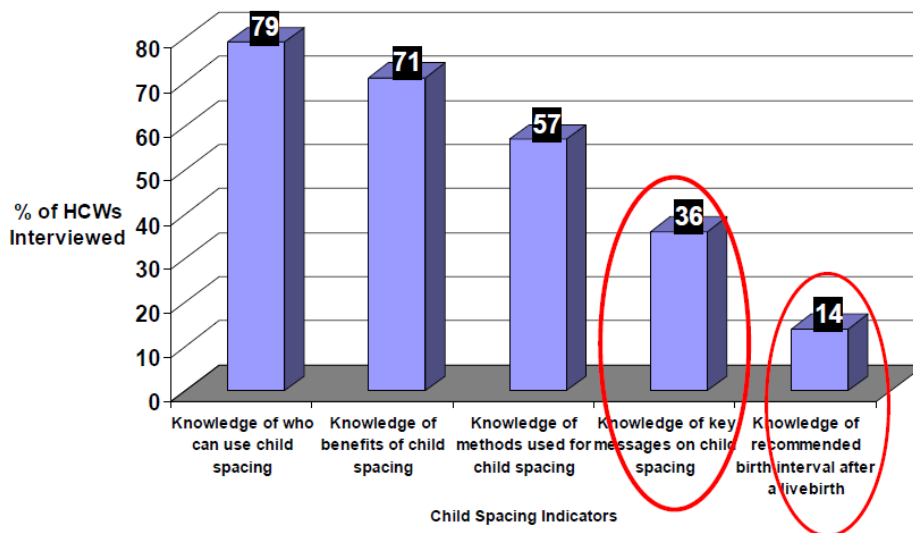


Figure 3
Knowledge of HTSP among Child Health Care Providers in Oecusse District, Timor-Leste (2008)



What we learned

The integration of HTSP into child survival programming is not easy to achieve, even if messages are clear and mechanisms for operationalization are viable. Like most aspects of child health, HTSP requires collaboration, and is therefore subject to the tension that exists between partners' differing agendas and the common goal of improving child health. It is fairly ordinary to see initial resistance to HTSP integration, based on the impression that it is not only an added burden, but that 10-20 minutes of attention to HTSP in multi-area counseling session may dilute the impact of other messages.

Clearly, HTSP does not stand alone—it is based on and complements mother and child health services, and depends on a functioning primary healthcare system. Thus, if there is a poorly functioning system in place, HTSP is nearly impossible to implement effectively.

One key factor that BASICS learned in several countries was the importance of the collaboration with churches to disseminate HTSP messages. Although the church is traditionally viewed with hesitation as a partner in programs based on modern contraception use, there can be no doubt that religious leaders are as eager as health professionals and policymakers to reduce maternal and child mortality. Experience in Rwanda and Timor-Leste showed that churches were willing information providers regarding the benefits of HTSP and, while they favor natural family planning methods, clergy did not directly condemn their use; and church-based health facilities consistently referred interested clients to secular health facilities.

A summary of lessons learned are:

- HTSP is not a stand alone program but complements other maternal and child health services—integration is the key;
- Functional PHC activities with constantly increasing performance for the essential MCH package in which the new HTSP interventions will be integrated;
- Readily available quality and complete data from the DHS is needed for baseline data as well as for planning;
- Political will with interested and influential public and church officials in various management and leadership functional structures is required—the need for HTSP champions;
- Locally appropriate tools can be developed if they are developed with and reviewed by representatives of various organizations and community groups;

- Training and capacity building of health care workers on HTSP should take place in an integrated manner with training of maternal and child health platforms including IMCI, ANC/PMTCT, immunization clinics, postnatal and other services;
- There needs to be supportive supervision and mentorship at all levels of the health care system;
- Nationally there is a need for monitoring of HTSP activities integrated with other health services and having established indicators for HTSP success.

What is the way forward for HTSP?

A considerable need in HTSP programming is consensus on indicators for monitoring and evaluation. In as much as HTSP continues to be insufficiently understood by mothers and families, it is necessary to move beyond simple measurements of contraceptive use and method mix (which essentially provide family planning data), and more directly look at the reach and retention of key messages about birth spacing.