INTEGRATION OF HEALTHY TIMING AND SPACING OF PREGNANCY WITHIN CHILD HEALTH SERVICES IN RWANDA

A RAPID ANALYSIS

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Executive Summary

As USAID/BASICS prepares to close in September 2009, lessons learned through the experience of integrating Healthy Timing and Spacing of Pregnancy (HTSP) within child survival activities should be documented for future work in other countries, in both the Family Planning and Child Survival fields. The BASICS Rwanda program has been one of the first projects to integrate HTSP within child health activities, and not only within family planning. As such, it was important to BASICS to clearly understand whether this is a successful model, and what recommendations could be passed on both to the MOH in Rwanda and to other countries seeking to integrate HTSP within child health programs. To this end, a rapid analysis of the integration of HTSP within child health services in Rwanda was conducted by BASICS, with the support of the Ministry of Health and Intrahealth/Twubakane in March/April 2009.

BASICS collected central- and facility-level data, reviewed policies and documents, and conducted interviews with sources at both levels. The program was evaluated for achievements in the following four key areas:

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, and that the implementation of HTSP in practice at the district level needs improvement. Government support for family planning is very strong in Rwanda, where population reduction is a national priority. Hence, family planning activities are extremely well-integrated within maternal and child health programs. In fact, Rwanda has been so successful at promoting family planning to clients that the message of birth spacing seemed lost within the better-understood concept of birth limitation.

This report recommends that HTSP messages be further harmonized within child health policy as well as maternal and family planning policy. Additionally, although a strong advocacy effort was successfully conducted at the outset of the project, more MOH and partner staff should be trained or sensitized in the role of birth spacing within the national family planning program. The HTSP component of the IMCI training program must be strengthened and given more emphasis, as well as more consideration in supervision. Finally, this report suggests that some type of IEC materials would be useful as job aids for health workers in the health center setting.

Background

Each year, more than 500,000 women die in pregnancy or childbirth and more than 10 million children die before their fifth birthday. Nearly 40% of these deaths occur in the first month of life. But evidence shows that at least 7 million of these children's lives can be saved each year with proven, cost-effective interventions.

One of these interventions includes the promotion of longer birth intervals for women over 18 years of age. Measure-Evaluation's 2002 study using DHS data from 18 countries in four regions found that children born 3 to 4 years after a previous birth are healthier at birth and more likely to survive at all stages of infancy and childhood through age five. They are also:

- *1.5 times more likely to survive the first week of life;*
- *2.2 times more likely to survive the first 28 days of life;*
- *2.3 times more likely to survive the first year of life; and*
- *2.4 times more likely to survive to age five*[1]*.*

A related study published by USAID-sponsored researchers also showed that, compared to 24 to 29 month birth intervals, 36 to 41 month intervals are associated with the following reduction in risk:

- *26% reduction in neonatal deaths,*
- *43% reduction in infant deaths, and*
- *51% reduction in under-five deaths.*

The best evidence indicates that 3 to 5 year birth birth intervals are associated with the *lowest* risk of death among children[2]. Longer birth intervals are also associated with nutritional status improvements. Compared to 24 to 29 month intervals, 36 to 41 month intervals are associated with a:

- *28% reduction in stunting, and*
- *29% reduction in underweight.*

Healthy timing and spacing of pregnancy (HTSP) can thus be promoted as a critical and essential child survival intervention with both health and non-health benefits to women, children, men, the family and the community. HTSP promotes three key messages:

1. Women should space the births of their children at least three years apart
2. There are important benefits to the health of the mother and children when properly spaced
3. There are several family planning methods that can help women achieve optimum birth spacing

Most mothers frequent child health services for various reasons related to their child's health, such as for well baby services, child illnesses, immunization, and growth monitoring. Child health services thus offer a unique opportunity to reach women with HTSP educational messages. USAID/BASICS' mandate is to scale-up the use of proven, effective, and evidence-based health interventions, including HTSP, to improve child survival in its target countries. The BASICS strategy to promote HTSP as a key child survival intervention is to place it within routine primary care for newborns and young children. Since 2006, BASICS, in collaboration with the Ministry of Health and local implementing partners (the USAID

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[1] Birth Spacing, Population Report, Volume XXX, Number 3 Summer 2002 Series L, Number 13 Issues in World Health

[2] Conde-Agudelo and Belizán, Maternal Morbidity and Mortality Associated with Interpregnancy Interval: Cross Sectional Study, British Medical Journal, 18 November 2000. http://bmj.com/cgi/content/full/321/727/1255

bilateral project Twubakane, UNICEF, WHO, Elizabeth Glazer Pediatric HIV/AIDS Foundation [EGPAF], Save the Children, the USAID Capacity projects) has supported the integration of HTSP in child health programming and activities in Rwanda. BASICS first worked on integrating HTSP into child survival policies, strategies and tools at the central level, and then collaborated with partners to train staff in district hospitals and health centers to promote HTSP through counseling and referral to family planning services.

Rwanda is the most densely populated country in sub-Saharan Africa, with a small land area similar to the size of the state of Maryland, and a population of 9.3 million. The fertility rate of 5.5 children/woman (only slightly changed from 6.2 in 1992) is high, and significantly higher than the desired rate of 3.3 children/woman. The contraceptive prevalence rate is 36% (27% with a modern method), which is relatively low but significantly improved from 13% in 2000. Among women who desire more children, the majority prefer to space them at last two years apart, with only 7% of women preferring a spacing of less than two years.[3] The children of 64% of women were spaced less than 3 years apart, and 23% are spaced less than 2 years apart.[4] Such high fertility rates not only contribute to increased child mortality as described above, but provide population pressures that impede economic development, which is of great concern to the government of Rwanda (GOR). Improving access to and use of family planning is a GOR priority.

The government recommends and promotes limiting family size to three children. Although this is not enforced through law, such informal communication from the government is often followed closely in Rwanda, where respect for authority is highly respected as a cultural value.

One reflection of the high priority the government places on reducing population growth is that all contraceptive methods are free and are widely available at nearly every health facility in the country (the only exceptions are the facilities run by the Catholic church). This includes pills, injectables, IUDs, implants, and the standard days method. Vasectomy and tubal ligation are also provided at some health facilities. Across the country, there is a very strong contraceptive logistics and supply chain system that ensures all health centers have a full stock of all methods. Stockouts of family planning products are very rare, and such uncommon cases are treated seriously and resolved rapidly.

Another indication of the GOR family planning priority is reflected in the compensation structure for health providers. Facility health providers are paid through a performance-based financing mechanism, which was initiated and is implemented by GOR with support from the national budget and from partners, according to the number of clients served in family planning, and quality of care provided, among other relevant health indicators. The more family planning clients they enroll, the more they are compensated. They are also compensated more highly for the clients who choose long-term methods such as vasectomy or tubal ligation (now being promoted heavily). Jadelle (an implant) is promoted as the limitation method, while the pill and injectables are used more commonly for spacing.

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[3] Ministère de la Santé (MINISANTÉ), Institut National de la Statistique du Rwanda (INSR) et ICF Macro. 2009. *Enquête Intermédiaire sur les indicateurs Démographiques et de Santé, Rwanda 2007-2008.* Calverton, Maryland, U.S.A. : MINISANTÉ, INSR et ICF Macro.

[4] Institut National de la Statistique du Rwanda (INSR) and ORC Macro. 2006. *Rwanda Demographic and Health Survey 2005.* Calverton, Maryland, U.S.A.: INSR and ORC Macro.

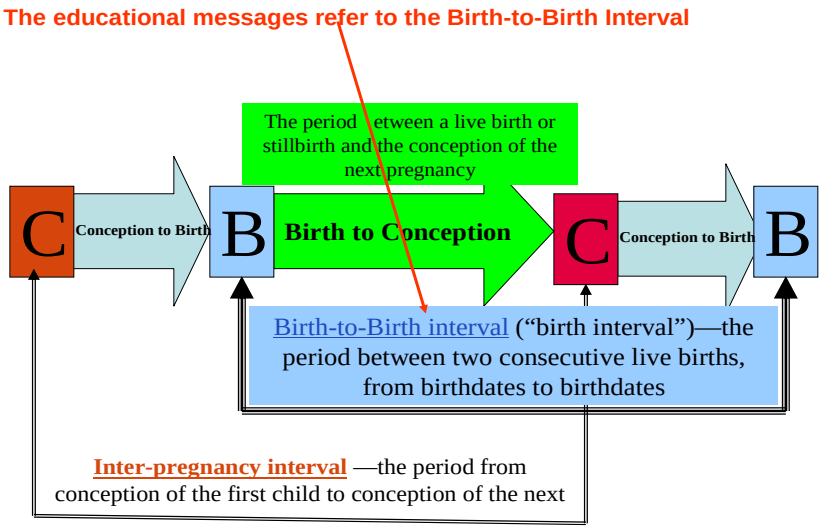
HTSP Promotion within Child Health – the BASICS Strategy

BASICS' strategy for integration of Healthy Timing and Spacing of pregnancy into newborn and child health programs is composed of five steps:

- Advocacy
- Collaboration with partners
- Integration of policy, management and training tools
- Implementation strategies
- Scale-up and expansion

Several generic tools were developed by BASICS, in collaboration with the ESD project, to support these steps. The first is an evidence-based advocacy presentation (see Annex 1), designed to create awareness and commitment for HTSP among target decision makers. During the advocacy session, BASICS discusses the key findings from the six USAID sponsored studies that highlight the significant health benefits of longer birth intervals and the health risks associated with short birth intervals. The presentation is introduced by the necessary clarification of the Birth-to-Birth interval, the reference used in the birth interval educational messages (see Figure 1). The presentation is designed to use the most recent DHS data from the target country to illustrate the relationship between shorter birth intervals and newborn mortality and define the estimated number of child deaths that potentially could be averted. In Rwanda, the presentation used local data to describe the potential Rwandan lives saved through effective implementation of HTSP.

Figure1: Definitions of pregnancy and birth intervals in HTSP



Another generic tool is the Methodological Guide (See Annex 2) for effective integration of HTSP into newborn and child health activities. The tool is based on the assumption that there are child health services in the health system where mothers can be easily reached. The methodological guide was developed by BASICS to assist program managers and newborn and child health service providers to effectively integrate HTSP messages into newborn and child health programs. The guide considers antenatal clinics/PMTCT, post-partum care, well baby clinic, child immunization, growth monitoring and nutrition clinics, facility IMCI, community IMCI and emergency sick child visits all as potential opportunities to discuss HTSP with mothers. The guide lays out the step in the process where HTSP would be brought up, how to assess the mother's family planning status in that setting, the messages that should be communicated to her, and any additional advice to the providers relevant to that specific situation. The guide can be adapted to specific country settings to walk policy-makers through the various entry points for HTSP.

Finally, BASICS developed a Monitoring and Evaluation Framework (See Annex 3) to assess the impact of introduction of HTSP into child health services. There are four key focus areas: integration of HTSP messages into routine essential newborn and child health programs; knowledge generation among women of child-bearing age; capacity building of child health service providers; and increased length of stay in a family planning program by women of child-bearing age. Indicators, definitions, outputs, outcomes, source of information, data collection techniques and frequency are noted for each key area.

HTSP in Rwanda

Objective

BASICS' program objective for HTSP in Rwanda was to introduce HTSP within routine newborn and child health activities. The steps for achieving this goal included:

- Incorporating HTSP in newborn and child health policies and strategies, including the post-partum package of interventions
- Incorporating HTSP within IMCI guidelines
- Implementing HTSP through IMCI-HIV strategy in trained districts
- Expanding HTSP at facility level and community level

Approach

In Rwanda, BASICS works at the policy level and does not work directly on implementation in the field. Rather, BASICS collaborates closely with partners who have direct impact on health facilities at the district level. Therefore, the approach to HTSP Integration was to work closely with the MOH to integrate key messages into family planning and maternal and child health policies, then support partners to implement the updated policies in the field. Through this approach, BASICS hoped to integrate HTSP in all child survival interventions taking place in the field.

Advocacy

The generic advocacy presentation mentioned above was adapted for Rwanda, using data from the USAID sponsored studies and country-specific DHS data, and was finalized by a BASICS HTSP consultant in February 2007. This short term technical assistance visit to Rwanda was very successful, providing the opportunity to meet, inform, sensitize and engage officials, decision makers and the implementing partners. High level discussions were held with key stakeholders and policy makers including the Minister of Health, a Senator, Chairperson of Social Affairs, Human Rights and Petition Committee at the Rwanda's Parliament/Senate, chairperson of the Rwandan chapter of the Forum of Women

Educationalists (FAWE), the Director of the School of Public Health, the USAID HPN officer and the USAID MCH specialist, and the UNICEF program coordinator, among others.

The advocacy presentation was shared with the MOH, USAID, UNICEF, the Twubakane project (USAID bilateral), UNFPA, the Child Health Working Group, and the Family Planning Working Group. The purpose of sharing the presentation was to increase awareness of the benefits of birth spacing, and to encourage participants to introduce and replicate the messages and skills within their programs. Participants were very receptive to the information and especially impressed by the use of local data to demonstrate the potential deaths averted by using ideal birth spacing. The Minister of Health, convinced of the added value to family planning, encouraged BASICS and partners to move forward with the integration and implementation immediately.

Integration

With permission from the Minister of Health, BASICS began to integrate the HTSP concept and key messages into all national policies and strategies that related to child health in 2006. The technical information about HTSP and messages to be delivered to clients was integrated into policies and implementation tools. Some documents, such as the Child Health Policy, Child Survival Strategy, and National Norms and Protocol for Service Delivery were not yet developed at the time HTSP was introduced, so HTSP was incorporated into those documents from their conception. Some policies or documents that were already in draft form (for example, IMCI guidelines) were integrated with HTSP guidelines, and then printed as final. The Family Planning Curriculum was updated to integrate HTSP.

BASICS also collaborated with the Immunization program of the MOH to integrate HTSP messages into the national immunization program. The immunization program in Rwanda is very successful, with 97% of children completely immunized before reaching 2 years of age.[5] Support to the EPI/MOH of Rwanda was provided to develop integrated messages on immunization and HTSP together for dissemination to clients at immunization sites.

At the community level, child health partners conducted formative research to analyze behaviors on key family practices for child survival. From that research, appropriate integrated messages were developed to promote child health, including messages on HTSP, HIV and nutrition which were used to create counseling cards. The cards are currently being produced and will be disseminated for use by community health workers in the field.

Partnership

BASICS' role in Rwanda is to provide technical support to the MOH for child health, and to assist the MOH in coordinating the various child health implementing partners in Rwanda. BASICS' role is not as an implementer; thus all on-the-ground implementation is provided through partners. Partner projects and organizations are implementing the national strategies and policies developed through the MOH with BASICS support. The key partners in HTSP implementation are two USAID bilateral projects, Twubakane and Capacity; UNICEF; the Expanded Impact Project (EIP); Save the Children; the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF); GTZ; and Cooperation Suisse.

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[5] Ministère de la Santé (MINISANTÉ), Institut National de la Statistique du Rwanda (INSR) et ICF Macro. 2009. *Enquête Intermédiaire sur les indicateurs Démographiques et de Santé, Rwanda 2007-2008.* Calverton, Maryland, U.S.A. : MINISANTÉ, INSR et ICF Macro.

Together, the partners met regularly under BASICS coordination to discuss HTSP integration issues, a common work plan for the implementation of HTSP, cost sharing, and generally to develop complementary actions to avoid duplication.

Implementation

The key implementing partners for HTSP were the USAID Twubakane project, EGPAF, Cooperation Suisse, German Technical Assistance (GTZ), UNICEF and the USAID Capacity project. These projects implement the child health policies and strategies of the MOH, including IMCI at both facility and community level, supporting roll out of family planning services at facility and community level, and supporting immunization activities. As HTSP was integrated within IMCI, Family Planning and Immunization programs, Twubakane, EGPAF, UNICEF and Capacity began implementing HTSP through their capacity building, supervision and monitoring activities.

Facility IMCI is currently operating in 30 of 30 districts in Rwanda, so every district in the country now has staff trained who were trained in HTSP during IMCI training functioning in health facilities. The Family Planning training program, a separate program from IMCI and also managed by the MOH, was conducted by the Twubakane and Capacity projects, and has covered 7 of 30 districts. Finally, immunization activities are standardized and conducted nationwide. Embedding HTSP messages within these national programs ensured the program would naturally be carried to scale in Rwanda.

Expansion

By March 2009, the first four steps in the HTSP promotion process (Advocacy, Integration, Partnerships and Implementation) had been completed. The final step, expansion, was reached quickly in Rwanda's case, due to the rapid scaling up of IMCI that included HTSP. There was no need to conduct pilot implementation because the HTSP message was extremely acceptable to the MOH as part of their focus on family planning. Once the information was included in policy, it was taken to scale with other programs, such as IMCI, which was successfully taken to scale (30 out of 30 districts) in June 2009.

Objectives and Methodology of the Analysis

Objectives

As USAID/BASICS prepares to close in September 2009, the lessons learned through the experience of integrating HTSP within child survival activities should be documented for future work in other countries in both the Family Planning and Child Survival fields. The objective in undertaking this rapid analysis of the integration of HTSP within child health services in Rwanda is to understand, simply, what worked and what did not work. The BASICS Rwanda program has been one of the first projects to integrate HTSP within child health activities, and not only within family planning. As such, it was important to BASICS to clearly understand whether this was a successful model, and what recommendations could be passed on both to the MOH in Rwanda and to other countries seeking to integrate HTSP messages within child health programs. The results of this analysis should be shared with the global health community to recommend best practices and a way forward based on results achieved in the field.

Based on the M&E framework developed at the outset of the program, the program was evaluated for how well it achieved in four key areas:

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

Evaluation team

BASICS collected central and facility level data and conducted interviews with sources at both levels. Two BASICS team members, a BASICS HTSP consultant and a representative of Twubakane undertook six days of field research to complete questionnaires with providers and clients at health centers and hospitals in six districts. BASICS staff then conducted interviews with key partners and MOH officials in Kigali, and collected and reviewed the documents and central level data.

Methodology

The rapid analysis was planned to capture initial results from the HTSP integration in Rwanda, and evaluate whether the activity had been well-conducted by health facility staff and well-understood by clients. The emphasis was on qualitative data with a few key quantitative exercises to address the expected indicators. The design of the analysis included a document review, collection of some training numbers and data, and in-depth interviews at central, district and health center levels.

Questionnaires were developed for In-depth interviews for the central level (MOH and partners), for the district hospital and health center in-charge staff, for providers, and for health center clients. The questionnaires were designed to collect qualitative information from each target group to gather their impressions, feedback and recommendations on birth spacing activities in Rwanda. The questionnaires also collected some quantitative date on the number of women enrolled in the family planning program at each health facility who had remained on a method for at least 3 years. The information from the questionnaires was coded and then analyzed in SPSS. The questionnaires are at Annex 4 and tables of contacts who were interviewed are included in Annex 6.

1) Document Review: The evaluation team collected final copies of all documents that included or should have included HTSP messages, including: Behavior Change Communication messages for community level; the National Child Health Policy and Strategy; the Policies, Norms and Standards for Health; the Facility IMCI training modules, the Emergency Maternal and Obstetric Care (EMOC) Manual; the Family Planning training modules; the Vaccination Card; Family Planning Client Intake Form; the Pediatric HIV case management algorithm; and the Community Health training modules. All documents were reviewed to analyze to what extent HTSP messages had been included and whether the message was correct.

2) Central Level Data Collection: The evaluation team collected the national data on numbers of people trained in IMNCI-HIV-BS and Family Planning sessions through On the Job Training (OJT). The evaluation team conducted In-depth Interviews with MOH officials who have been involved with various aspects of child health that include birth spacing and family planning to gather their opinions, feedback and suggestions for improvement regarding the HTSP activities. They also met with representatives of the Twubakane and Capacity projects, who were the key implementing partners for HTSP activities with BASICS. (See Annex 6 for a list of interviewees).

3) District and Health Center Data Collection: To gather the facility level data, the evaluation team (divided into two groups of two) visited six districts, three in the southern part of the country and three in the east, over six days in March and April 2009. Within each district, teams visited 3-4 health centers (centre de santé) and the district hospital. A total of 23 health centers and 6 district hospitals were visited over the six day period. In the district hospitals, the teams interviewed the

Hospital Director, Head of Maternity, IMCI Supervisor and Family Planning Coordinator. At the health center, the teams met with the head of the center (Titulaire) and providers working in Family Planning, the Maternity and IMCI. They also interviewed at least 3 clients exiting those services. (See Annex 4 for the questionnaires use, Annex 5 for the detailed list of field visits and Annex 6 for a list of positions interviewed).

Results

Number of staff trained on HTSP

During the four years of BASICS implementation of IMCI, 1,033 personnel were trained on the IMCI-HIV-HTSP modules. Family Planning training conducted through the OJT program covered 253 staff from Twubakane-supported districts in the country.

Document Review

BASICS' role in providing technical assistance to the Ministry of Health on child health policy provided a unique opportunity to include HTSP messages in policies and documents as they were being developed. Thus, HTSP messages should have been included in all key documents, unless they had been changed or produced without BASICS review. For the purposes of this evaluation, all MOH documents relevant to child health were analyzed for whether they included the HTSP messages and whether the message was correct.

In the package of Behavior Change Communication (BCC) messages developed for the community level, HTSP messages addressed several different target audiences: parents, couples, family members, community health agents, local and religious authorities and teachers. Messages were tailored for each target group, they reiterated the benefits of birth spacing for the child, the mother, the family and the community, while also defining the correct interval.

The National Child Health Policy document covers definitions, objectives, strategies, activities, beneficiaries and those responsible for child health in Rwanda. It is the critical document that guides all child health interventions in the country. In the document, birth spacing and its proper interval is discussed at all stages of life of a child starting from pre-conception, and including pre-nuptial, pre-natal, post-natal, growth monitoring and IMCI visits.

The Policies, Norms and Standards for Health in Rwanda (Draft) summarizes the national policies for health, and the health system management. In Family Planning, Child Survival and Maternal Health sections, recommendations are made on when to share advice on birth spacing. Several documents should be added to the Policies, Norms and Standards. In the Child Survival section, a technical sheet on the benefits of birth spacing and a guide for counseling mothers on birth spacing should be included. For the Family Planning section, a technical sheet on the benefits of birth spacing and the card given to mothers at vaccinations that describes benefits of birth spacing should be included. Finally, the key messages about birth spacing should be included in the annex of the document.

The MOH's Family Planning training modules is intended to facilitate the integration of family planning into all services provided at a health facility. The document has three pages dedicated to birth spacing, including general information on the concept of pregnancy spacing, messages about the exact timing of spacing between pregnancies, and the benefits of pregnancy spacing. It also suggests the most appropriate times for sharing which messages with clients.

In the Facility IMCI manual, the algorithms that health workers use for reference were checked for HTSP information. One page in the manual discusses the benefits of birth spacing. For a woman who is not using a contraceptive method, the advice is focused on the advantages of birth spacing, the risks

associated with a short space (less than three years), and how and where the woman could get a birth control method. For the woman who is using a contraceptive method already, the benefits of spacing births at least three years apart is given, and the woman is encouraged to continue using birth control for at least 2 years after a birth. The birth interval given in this document suggests at least three years between births, which could be difficult for some clients to understand, since they will have to calculate the last birth, plus three years, minus nine months to arrive at the date where they should get pregnant. The document should be refined to clearly state the recommended interval between a birth and the following pregnancy.

Also in the Facility IMCI manual, the module on counseling the mother includes general information on the concept of pregnancy spacing, messages about the exact timing of spacing between pregnancies, and the benefits of pregnancy spacing. A role play that allows participants to discuss and better understand the issues surrounding birth spacing should be added.

In the Emergency Obstetric Care manual for health center providers, birth spacing is not integrated, and there is no explanation of the differences between family planning (methods) and birth spacing (using methods to achieve a specific gap). Unfortunately this document is currently awaiting signature from the Minister of Health, but should it be revised in the future, a distinct section describing the benefits of birth spacing should be included.

The IMCI Algorithms to help providers evaluate and classify the sick child (from zero to 7 days, from one week to two months and from two months to five years of age) includes HTSP messages on the revised sick child consultation card. The integration of these HTSP messages on the sick child card provides a good reminder for providers to talk with the mother about birth spacing. However, a section on birth spacing that describes the concept, gives the key message and benefits, and differentiates between limitation and spacing should be included.

The Vaccination Card, the immunization reference for providers, integrated the key messages on birth spacing, pediatric HIV and vaccination to be shared during vaccination sessions. The card is awaiting approval from the central level before field testing.

The client intake form for Family Planning has included the correct messages on birth spacing. The provider asks the client whether they are interested in limiting or spacing births and then gives information according to their choice.

The Pediatric HIV case management algorithm for provider reference has integrated the correct messages on birth spacing, and is awaiting validation from the Ministry of Health.

In the Community Health manual for providers, the correct messages on birth spacing are included.

Nutrition documents that have integrated HTSP messages include the Feeding Guidelines for the Non-Breastfeeding Child (an annex to the national nutrition guidelines for PLWHA) and counseling cards which are currently being developed for the community based nutrition program and for the feeding of the non-breastfed child.

Qualitative findings

The qualitative findings from this report were gathered through in-depth interviews with clients, providers, and policy makers at health center, district and central levels. Questionnaires were designed for each target group to gather their impressions, feedback and recommendations on birth spacing activities in Rwanda. The following were common themes that were observed by the evaluation team during the interviews.

Technically, family planning is defined as a means to both limit the number of births and determine the space between those births, and the wide variety of methods available support both. Family planning is a national priority in Rwanda to reduce population growth. Birth spacing contributes to that goal, but also aims to promote the health of the mother, child and community. Unofficially, the emphasis in family planning activities in Rwanda has been on limiting births, rather than spacing births. This is evidenced by the fact that significantly more pages of text in training manual for Family Planning, Maternal Health and IMCI are given to discussing family planning for birth limitation, and one page or less to discuss birth spacing. MOH staff suggested that now is a good time to advocate for any changes needed in these training materials to reinforce birth spacing messages within.

Birth spacing has not been strongly emphasized during provider training. It is usually mentioned but not given as much time for discussion as limitation and methods. There should be more time for discussion of HTSP during trainings, and the MOH and partners should ensure that all the trainers correctly understand the difference between spacing and limitation. Additionally, the MOH felt that more training is needed to help providers understand the difference and about the methods available, and that implementing partners should take responsibility for reinforcing the birth spacing messages within their staff and programs. Training should also be conducted with the private sector.

There is a visible gap between the policy level at the MOH, where birth spacing, though a new approach, is considered important by the MOH MCH personnel, and the health provider, who is not talking about birth spacing. All of the interviewees at the central level were passionate about the importance of birth spacing for its benefits to maternal health, child health, and family economics. The consequence of having fewer children when they are spaced at least 3 years apart was usually named as a secondary benefit. However, most health providers in the facilities, when asked about birth spacing, would pause and do a mental translation, then begin talking about birth limitation. To most providers we met, birth spacing seemed to mean using family planning to limit births. It was only after pressing for specific information about the birth interval that they would discuss birth spacing. However, the concept of birth spacing seems innately understood at the household level, even if providers are not discussing it in conjunction with family planning services. Clients who were interviewed could immediately discuss why spacing children further apart provided a benefit to the mother, child and family. The connection between the value of birth spacing at the policy level and the family planning practices at the health center level need to be strengthened; birth spacing discussion needs to happen at the point of contact between the health provider and the client, who should be able to link a method to their desire to create more space between their births.

There seems to be some reluctance among policy makers and providers to focus specifically on birth spacing because they believe that if the number of women using family planning increases, regardless of whether they use it to limit or space births, there will naturally be more spaces between births. They seem to prefer to focus solely on provision and maintenance of methods for mothers, and not do counseling for birth spacing. The special benefits of spacing may need to be reinforced with both the

policy level and the provider level so that it does not continue to be filed under general family planning promotion.

Many key child health partners and MOH staff attended the advocacy presentation that BASICS conducted at the outset of the HTSP work, but there has been some turnover since then, and both the MOH and partners felt it might be useful for BASICS to conduct the advocacy presentation again, both at the MOH and with the child health partners.

Policy makers emphasized improving Information, Education and Communication (IEC) strategies. They suggested that posters and other mass media communication could be helpful in multiple sectors and venues, not only health facilities. Some also thought that existing BCC messages need to be coordinated to include both limitation and spacing.

When we told providers that we wanted to talk to them about birth spacing, they would respond to us about family planning programming and methods. We therefore noted that the difference between family planning (any method of preventing pregnancy) and birth spacing (as one of those methods) is not well understood. Family planning methods help families both limit and space their children. If providers promote family planning methods only for the purposes of limiting pregnancies, then the opportunity to discuss the benefits of spacing between pregnancies is lost. If a family has only three children but they are spaced closely together, the health of those three children (and their mother) continues to be at risk. More families involved in the family planning program at health facilities may need to hear the message that they can use family planning methods to have the number of children they desire, but they should be properly spaced.

Because two different methods for calculating the ideal birth spacing interval have been used in previous provider training, communicating appropriate information to caretakers has been challenging. Whereas some providers learned that the ideal spacing interval is 3-5 years *between births*, others learned that it is 2 years *between birth and conception*. Although both methods of calculation essentially yield the same result, it is clear that caretakers more easily understand (and follow) the principle of spacing when it is expressed to them as a two-year period from birth to conception.

Clients were generally able to give the correct recommended space between births, but providers gave mixed messages about the timeframe, based on different messages they've received in their trainings. Some providers said the space between births should be two years, which is the ideal birth to conception interval. Many said 4 or 5 years, which technically was considered as correct, but may be asking mothers to wait longer than they are willing. The fact that clients could usually give the correct response of 3-5 years may reflect an ideal interval preferred by the community, but not necessarily communicated by the providers during counseling. It could also reflect families' economic choices.

The message of birth spacing is not overly complicated; in fact, families throughout human history have practiced birth spacing, using either abstinence or prolonged breastfeeding. Most clients saw a clear difference in the economic situation of families with children spaced further apart. They observed that those families had better clothing, more money, and healthier children and mothers. These were perceived as benefits to having fewer children and more spacing. These commonly held beliefs need to be linked to family planning methods at the health facilities.

The most popular method used by women, according to policy makers, providers and clients, seem to be long-term methods, especially injectables. One MOH official suggested that if the emphasis of the

government and the choice of women continues to be the long-term injectables, that longer spacing will be achieved naturally.

The research team confirmed that methods were widely available at health facilities, and clients were confident about the availability of methods at their health facility. Most seemed to take for granted that any method they desired would be available to them that day for no cost.

The providers at most health facilities visit communities on a monthly basis to lead discussions on health issues and to provide preventative services such as family planning, vaccination, etc. We perceived a strong commitment to this exercise, and most health providers suggested these visits as an ideal place and time to discuss HTSP with the community.

Several innovative approaches were discovered at some health facilities:

- *Association des Hommes*: A men's association was started at one health facility, where male clients serve as peer educators with other men to support family planning.
- Increased payment for xouples xounseling: in Rwanda, the health centers are given a sum of money for every family planning member. A portion of this money is given as a fee to CHWs, who bring clients to the center. In one facility, CHWs who brought couples for family planning counseling received a higher fee than those who brought women alone.

Quantitative findings

The quantitative data presented below was calculated from the questionnaires conducted with clients exiting services at health centers, with providers at health centers and district hospitals, and with hospital directors and the heads of health centers. Information was coded and entered in SPSS to generate the following figures.

1. Client Survey (n=67)

- 37. 3 % of clients who gave the ages of their children have spaced births between 3 and 5 years
- 77.6 % of clients received information on HTSP during their consultation and 82.3 % of the information given was correct
- Most clients were able to list the benefits of spacing for children (75.0 %), mothers (69.2 %) and their community (57.7 %)
- 65.7 % of clients used a family planning method in their home
- 62.3 % of clients said that men are involved in family planning
- 100% of clients said that they would share information on HTSP with their neighbors
- 95.5 % of clients reported that family planning methods were available at their health center. The only exception to this was Ruhango Health Center, which is a Catholic center that does not provide modern methods.

2. Provider Survey (n=65)

- 55% of providers replied correctly when asked to give the recommended interval between births
- When asked to list the key messages they share with clients about HTSP (which are the advantages, the methods, and the interval),
  - 72.3 % providers mentioned the advantages of spacing,
  - 63.1 % providers mentioned that methods are available to space births, and
  - 4.6 % providers mentioned the births should be spaced 3-5 years apart (possibly because they were thinking of the key messages for family planning, and not for the messages for spacing)
- 75.4 % of providers believe that clients adhere easily to HTSP
- 49.2 % of providers believe that men are involved in HTSP
- 38.5 % of providers say that they receive regular supervision (in IMCI,EMOC or FP)
- Providers cited lack of awareness (55.4 %), religious beliefs (24.6 %), perceived lack of agreement from their husband (17.0 %), and fear of secondary effects(35.4 %) as the primary barriers to women accepting HTSP

3. Hospital Director/Titulaire Survey (n=22)

- 38.4 % of staff present in health facilities were trained in either IMCI, EMOC or Family Planning (the only programs that discuss HTSP).
- Information on number of women who started on a family planning method in February 2007, and the number of those women still using the method in February 2009 was collected from the data register at each facility visited. 47.8% of women who started on a family planning method in February 2007 were still using the method in February 2009 (n=677)

Discussion

What worked well?
The use of demographic data from Rwanda in the advocacy presentation which demonstrated the potential of Rwandan deaths averted was a key facilitating factor for advocacy with stakeholders. When the numbers were presented, birth spacing got the attention of policy makers.

There are multiple entry points for HTSP in child survival policies and strategies that provide opportunities to integrate birth spacing messages. During the short duration of this program, only a few points were used (family planning, IMCI and immunization) but we learned there are ample opportunities to talk about birth spacing in health programs. For example, further integration could be conducted with maternal health, obstetric care, and pre-and post-natal care. There are many more possibilities for this work.

HTSP messages and information were successfully added into the family planning and IMCI documents and training programs. Although the mentions are brief in contrast to the length of the documents, and HTSP is not covered well enough in training, the concept is at least present in the essential documents, which is an important start.

What did not work?
The unfortunate but predictable gap between policy and implementation is a problem for HTSP in Rwanda. Despite the fact that HTSP is clearly integrated into policy, strategy and training documents, implementation of the messages is weak compared to other topics within FP and IMCI.

The limitation of BASICS' role to policy work has handicapped their ability to affect field implementation, and may have contributed to some of the weaker implementation results. The integration of HTSP strategy into other services was done using advocacy and through updating or drafting new policies, strategies and training materials, but these activities alone were not able to yield maximum results for impact at the district level.

Within Family Planning activities, the message of birth limitation is widely disseminated and promoted. Messages on spacing births, which should be complementary to limitation, are clearly a second priority behind limitation. Some providers and policy makers perceived that HTSP messages did not conform to the birth limitation policy, a high level priority for the GOR, which negatively affects the likelihood that HTSP messages will be well-communicated to clients.

Facility health providers who were trained with materials that included the HTSP messages did not clearly understand or promote the information provided on HTSP strategy in the documents. This indicates a gap in the existing training where HTSP is not well-taught or highlighted.

The MOH and partners did not emphasize HTSP as a family planning strategy; rather, they considered birth limitation as the major strategy and structured their promotion activities around this objective (i.e. promoting permanent methods such as tubal ligation and vasectomy as a family planning method).

The systematic follow up of the HTSP strategy integration and implementation, both at policy and implementation levels, was insufficient. A better way to ensure HTSP remained visible would have been to dedicate one person at the MOH to the follow up, who was able to apply continuous energy to HTSP within the MOH and with partners.

In general, the dissemination of the HTSP messages was not broad enough; many facility health providers are still unclear on the difference between limitation and spacing, and are not able to effectively communicate the benefits of spacing to clients.

What do we now know?

HTSP integration into child survival interventions is feasible; there are good, natural opportunities to include the messages where they will benefit mothers and children. And the desired final outcome is achievable: maintaining enough women in a family planning program for a minimum of 2 years to achieve the objective of a 3 to 5-year birth interval.

The key players in family planning and child health at the MOH understand the difference between limitation and spacing, and believe both are valid routes to improving family planning in Rwanda. The concept of birth spacing is well-accepted at the policy level, and in general policy updates have taken place. HTSP integration into policy documents is a good start, but just the beginning of the integration process. Ensuring implementation is thoroughly carried out is absolutely critical to achieving intended results.

HTSP is included in most child health and family planning policies, but not necessarily well-understood by the trainers and by the implementers. Currently, HTSP is hidden within the larger messages of family planning, especially birth limitation. Implementation of the strategy at the district level is therefore weak. HTSP must be recovered and emphasized within Family Planning and IMCI training and supervision programs.

The clients at the service provision level demand family planning for both spacing and limitation. Methods are widely available for both choices.

Most people (providers and clients) are not clear about the differences between birth spacing and limiting births. However we also know that providers and clients can quickly grasp the difference when it is clearly explained.

A major challenge is the lack of time overwhelmed providers have to spend with each patient. The aspect of implementation that suffers the most from this lack of time is counseling. The integration of HSTP into child health services relies heavily on education and counseling skills, and the time to do both well. This component requires strengthening within both the FP and IMCi programs in Rwanda.

What do we still not know?

We are still not sure whether young couples are inclined to adhere to the recommended spacing, or other information related to age of the mother. Anecdotally, we heard about young couples who want to have all their children quickly and closer together, then use a permanent method. It would be useful to have more research on this specific question.

We do not know the exact numbers of women who are using a family planning method to limit births and those who are using family planning to space births. More rigorous data collection would need to be done to better understand who is using modern contraceptive methods and for what purpose.

If we could do Rwanda over again, what would we do the same and why, and what would we change and why?

We would use the same process to introduce and integrate HTSP into child survival interventions: conduct advocacy to gain government and partner support, integrate HTSP into policy and training; and expand through implementing partners. In the future, however, we would strengthen the visibility of HTSP within child health training programs and conduct more follow-up through supervision, refresher trainings and ongoing advocacy.

Although we would use the same process, we would encourage the creation of a position or person responsible for HTSP at the MOH in family planning. The MOH is currently overburdened with few people to do much work, and new messages such as HTSP will inevitably disappear if there is not an advocate within the Ministry to promote the intervention.

The priority family planning message in Rwanda is to limit births to control population growth. A message that clearly states the essential contribution HTSP makes to population control should be developed and disseminated to stakeholders. Existing family planning messages that emphasize limitation without mentioning spacing should be assessed and harmonized so that all family planning messages discuss BOTH limitation and spacing.

In the future, we would provide more information on the HTSP strategy to health providers to ensure that they themselves understood the information and the benefits to better communicate with clients. Advocacy could be done in form of seminars or workshops, pooling together all the stakeholders under the leadership of MOH and the lead partner(s) in HTSP.

Are there enabling factors?

The most important enabling factor was that family planning is a high priority intervention for the GOR. Though the focus within family planning has previously been on limitation, the policy makers with whom BASICS met and worked were very open to the idea of promoting the program and integrating the key messages within policies and guidelines. There is more progress to be made on raising awareness of birth spacing as a method, but once policy makers and providers understand the concept, they are very willing to include it. If the government places a high value on use of modern contraceptive methods, HTSP can be accepted by policy makers, stakeholders and communities.

The family planning logistics supply chain is very well-managed in Rwanda, and the widespread availability and infrequency of stock-outs enables clients to have confidence in health facilities to meet their contraceptive demands. Increasing demand for contraceptives to space births would be of little use if the actual methods were not available.

BASICS' excellent working relationship with the MOH ensured a receptive audience to suggestions and provided access to the policies and other documents to integrate with HTSP.

Are there pre-requisites before starting HTSP?
There are a few essential pre-requisites to ensure that the integration of HTSP within child health is well-received and can be successful. As stated above, government support for family planning is critical, and a continuous availability of modern contraceptives through a strong family planning logistic mechanism to respond to the demand created should already be in place.

Existing child survival interventions should be strengthened and brought up to a reasonable level of competency before integrating HTSP; integrating a new activity into a low performing program/intervention is not technically recommended.

Conclusion

The rapid analysis found that, in general, the integration of HTSP messages into child health policy was successful, and that the implementation of HTSP in practice at the district level needs improvement. Government support for family planning is very strong in Rwanda, where population reduction is a national priority. Hence, family planning activities are extremely well-integrated within maternal and child health programs; in fact, Rwanda has been so successful at promoting family planning to clients that the message of birth spacing seemed lost within the better-understood concept of birth limitation.

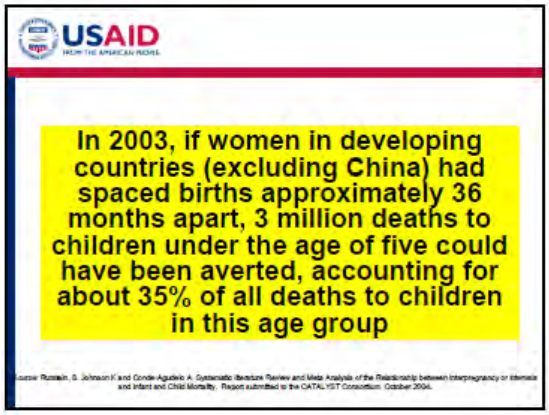
There remains a need for the HTSP messages to be further integrated within child health policy as well as maternal and family planning policy, outside of IMCI and Family Planning training programs. Additionally, although a strong advocacy effort was successfully conducted at the outset of the project, more MOH and partner staff should be trained or sensitized in the role of birth spacing within the national family planning program. The HTSP component of the IMCI training program must be strengthened and given more emphasis, as well as more consideration in supervision. Finally, IEC materials would be useful as job aids for health workers in the health center setting and to use for mass media such as posters.

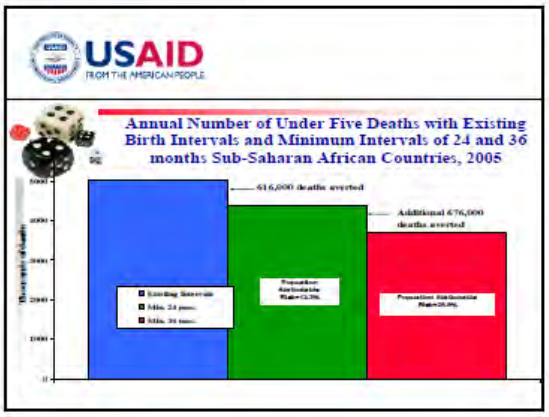
<u>Recommendations for HTSP in Rwanda</u>

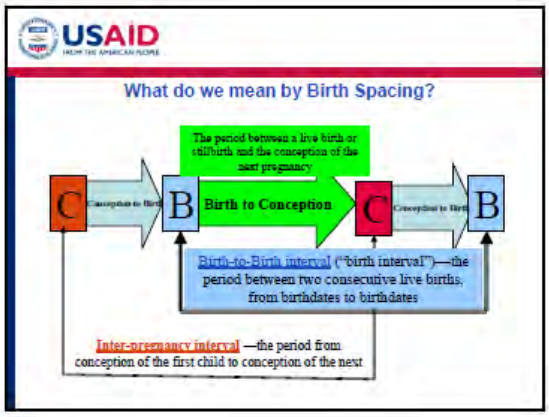
- Organize meetings to share the advocacy presentation to a wider group of policy makers at the MOH and other government ministries, as well as additional presentations with family planning and child health partner organizations and projects, to increase stakeholders' familiarity with the strategy and benefits of HTSP. HTSP should be a topic of discussion for one meeting (including the advocacy presentation) with the Family Planning Working Group and the Child Health Working Group to ensure that HTSP is solidly included as a priority intervention within the activities of those partners.
- If at all possible given budget and HR constraints, a new or existing position should be identified at the MOH as a point person for the HTSP strategy to continue to follow up on integration issues, ensure continuity, and keep HTSP visible among all policy-makers.
- Develop counseling cards, posters and other IEC materials to be used in health facilities to help health workers communicate messages about HTSP with clients. These should be disseminated as part of the IMCI program, and should be included in the C-IMCI counseling card package. Some of the material could also be used for a mass media campaign, to promote the HTSP message outside of health facilities.
- Emphasize the use of family planning for two different and equally important purposes (spacing and limitation) in all trainings where family planning is discussed: EMOC, IMCI, C-IMCI, Family Planning, etc. Family planning should mean having the number of children you want, when you want them

- There is a space on the consultation form in Family Planning services which asks the client about her desired spacing between children; the same question should be included on C-IMCI and SONU forms to trigger discussion on spacing with clients. All client intake forms in country should be analyzed and revised to include the number of children and their ages so that health workers can discuss spacing with mothers whose children are spaced closely.
- The indicator that should be used to track HTSP would measure the number of women who stay on a method for at least two years. This indicator should be included in all national standards and measurement. But more consideration needs to be given to how we find out how many of those women are staying on a method to space pregnancies versus those women who are staying on a method because they have already achieved the number of pregnancies desired.
- Several documents should be added to the Policies, Norms and Standards. In the Child Survival section, a technical sheet on the benefits of birth spacing and a guide for counseling mothers on birth spacing should be included. For the Family Planning section, a technical sheet on the benefits of birth spacing and the card given to mothers at vaccinations that describes benefits of birth spacing should be included. Finally, the key messages about birth spacing should be included in the annex of the document.
- The Facility IMCI Manual should be refined to clearly state the recommended interval between a birth and the following pregnancy (two years from birth to pregnancy, rather than three years from birth to birth). A role play that allows participants to discuss and better understand the issues surrounding birth spacing should be added.
- Several documents should be added to the Policies, Norms and Standards. In the Child Survival section, a technical sheet on the benefits of birth spacing and a guide for counseling mothers on birth spacing should be included. For the Family Planning section, a technical sheet on the benefits of birth spacing and the card given to mothers at vaccinations that describes benefits of birth spacing should be included. Finally, the key messages about birth spacing should be included in the annex of the document.

Annex 1: Advocacy Presentation







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Important proportion of women have short birth intervals – case of Rwanda

23% Birth Interval < 2 years

41% 2 < Birth Interval < 3 years

36% Birth Interval ≥ 3 years

Source: Rwanda DHS-III, 2005

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Important proportion of women have short birth intervals – case of East Timor

28% Birth Interval < 2 years

38% 2 ≤ Birth Interval < 3 years

34% Birth Interval ≥ 3 years

Source: Timor Leste 2003 DHS

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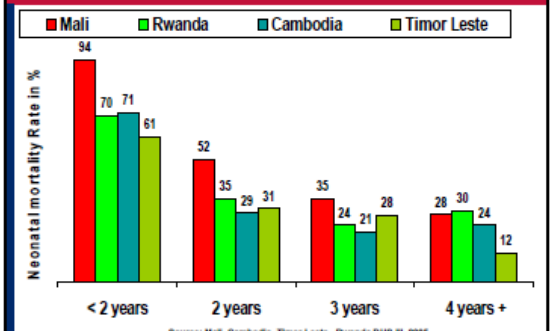
The shorter the Birth Interval the Higher the Neonatal Mortality Rate



Source: Mali, Cambodia, Timor Leste, Rwanda DHS-III, 2005

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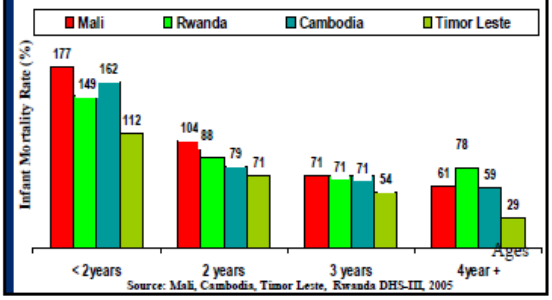
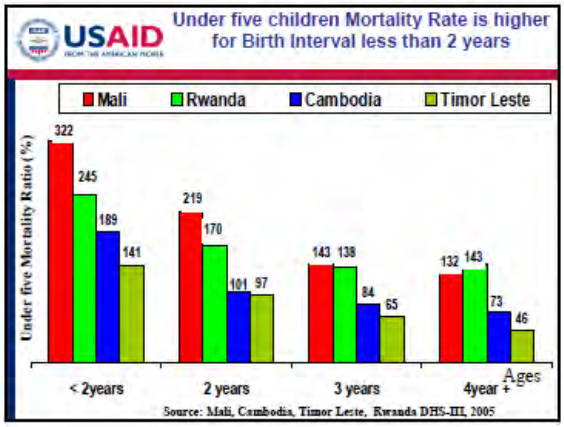
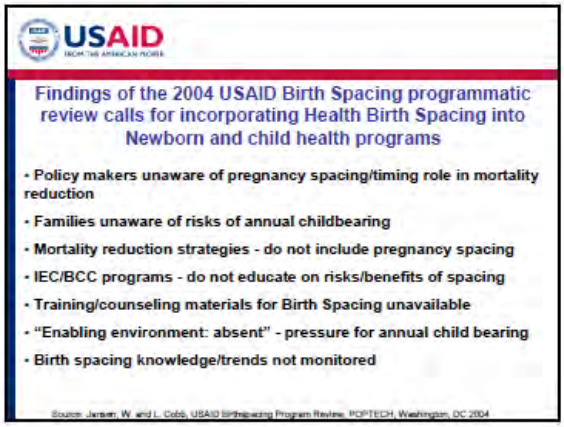
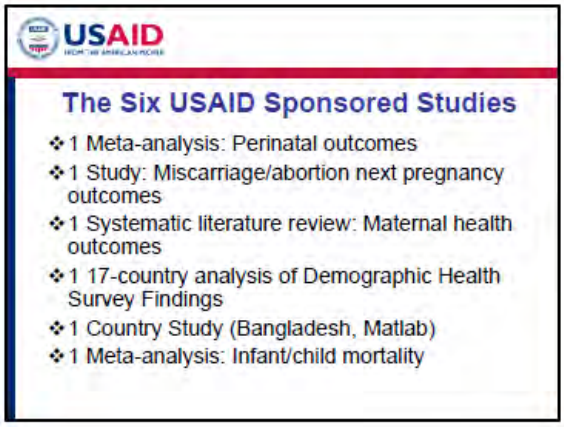
Infants are twice as likely to survive if the previous birth interval is at least 2 years

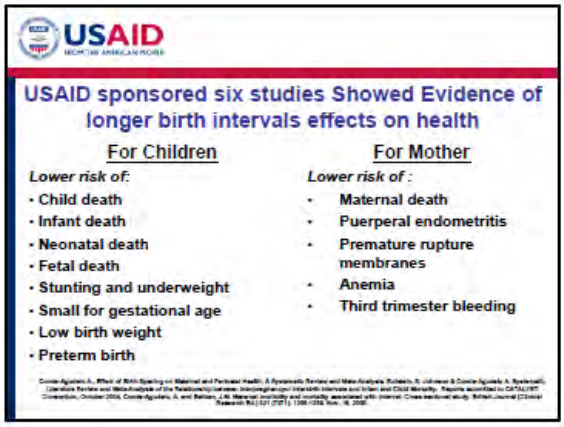


Source: Mali, Cambodia, Timor Leste, Rwanda DHS-III, 2005


USAID
Under five children Mortality Rate is higher for Birth Interval less than 2 years
Mali
Rwanda
Cambodia
Timor Leste
Under five Mortality Ratio (%)
322
245
189
141
219
170
101
97
143
138
84
65
132
143
73
46
< 2years
2 years
3 years
4year +
Ages
Source: Mali, Cambodia, Timor Leste, Rwanda DHS-III, 2005


USAID
Findings of the 2004 USAID Birth Spacing programmatic review calls for incorporating Health Birth Spacing into Newborn and child health programs
• Policy makers unaware of pregnancy spacing/timing role in mortality reduction
• Families unaware of risks of annual childbearing
• Mortality reduction strategies - do not include pregnancy spacing
• IEC/BCC programs - do not educate on risks/benefits of spacing
• Training/counseling materials for Birth Spacing unavailable
• "Enabling environment: absent" - pressure for annual child bearing
• Birth spacing knowledge/trends not monitored
Source: Janetti, W. and L. Cobb, USAID Birthspacing Program Review, POPTECH, Washington, DC 2004


USAID
The Six USAID Sponsored Studies
❖1 Meta-analysis: Perinatal outcomes
❖1 Study: Miscarriage/abortion next pregnancy outcomes
❖1 Systematic literature review: Maternal health outcomes
❖1 17-country analysis of Demographic Health Survey Findings
❖1 Country Study (Bangladesh, Matlab)
❖1 Meta-analysis: Infant/child mortality


USAID
USAID sponsored six studies Showed Evidence of longer birth intervals effects on health
For Children
Lower risk of:
• Child death
• Infant death
• Neonatal death
• Fetal death
• Stunting and underweight
• Small for gestational age
• Low birth weight
• Preterm birth
For Mother
Lower risk of :
• Maternal death
• Puerperal endometritis
• Premature rupture membranes
• Anemia
• Third trimester bleeding

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Birth Intervals' effects on Newborn and child health

- 24 months birth intervals, or longer, are associated with lowest risk (LBW) of stunting and underweight among under-five children
- LBW is an indirect cause of 60-80% of neonatal deaths and there are 18 million LBW infants born annually
- Risk of death among under-five children is lower if the preceding birth interval was loner than 24 months

Source: United States Agency for International Development (USAID), Bureau for Global Health, Office of Population and Reproductive Health, Washington, D.C. 20523-3600. December 2002. (WWW.USAID.GOV)

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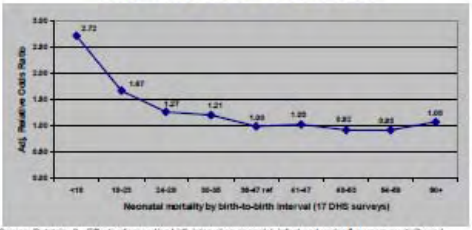
Neonatal mortality risk declines with increasing birth-to-birth interval length up to 48-59 months



Source: Rutstein, S., *Effects of preceding birth interval on neonatal, infant and under-five years mortality and nutritional status in developing countries: evidence from the demographic and health surveys*, International Journal of Gynecology and Obstetrics, 2005, 89, 57-524.

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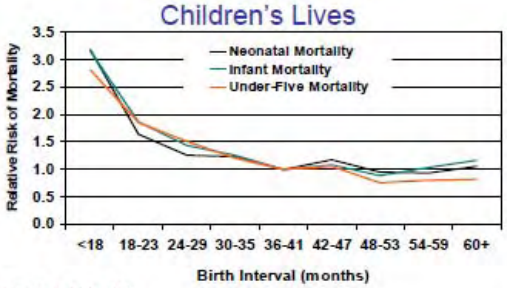
Birth Spacing Saves Children's Lives



Source: Rutstein, 2003

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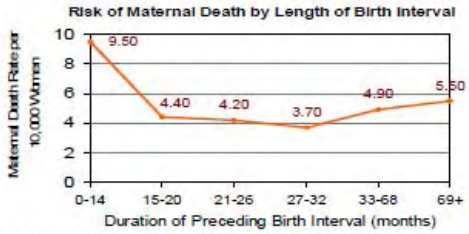
Birth Spacing Saves Mothers' Lives



Source: Conde-Agudlo and Belizan, 2000

USAID

African Birth Interval Preferences

- Mothers in Sub-Saharan African countries would prefer longer birth intervals.
- Few African mothers prefer birth intervals shorter than 36 months.
- Preferred birth intervals are usually longer in East and Southern Africa than in West and Middle Africa
- Few post–partum women want another birth within two years, yet many do not use family planning

Source: Shea Rutstein, PhD, Measure/DHS+,Macro International, Inc.

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Consequences of shorter birth interval

- When births are too close, families cannot take care of several small children, they are weaned too soon, and they are thus at greater risk of dying;
- When children are weaned too soon, their growth suffers, they are more likely to suffer from diarrheal disease, and skins infections, and they are thus greater risk of dying
- When women have too close pregnancies, they have greater risk of pregnancy related and delivery complications
- Spacing births more than 24 months can reduce the risk of morbidity and mortality for mothers and children.

Source: Shea Rutstein, PhD, Measure/DHS+,Macro International, Inc.

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Suggested Strategies to help couples space Births

- Increase access to good-quality contraceptive services and full range of methods,
- Encourage community campaigns that speak about needs of younger couples – and cultural norms and tradition beliefs,
- Use prenatal and post natal periods as crucial times for information and counseling about birth spacing,
- Discuss with mothers during well-baby and immunization visits the benefits of maintaining 3-5 years for the next child,
- Support initiative that strengthen the women decision-making power in the household.

Source: Population Reports, Volume XXX, Number 3, Summer 2002 (11)

USAID

WHO Recommendations for Spacing

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

WHO, Report of a WHO technical consultation, policy brief, Dept of ending pregnancy adm, Dept of RH research, Geneva, 13-15 June, 2006

USAID

BASICS' Overall Strategy: Combining Tailored Advocacy Interventions with Well Selected service Delivery Activities

The Advocacy Component:
-**Audience**: High level decision makers, program managers, leaders+

-**Content**: convincing information about effects of HTPS on child health using country data, regional data and new findings from the USAID sponsored six studies

-**Methodology**: evidence based approach using various methods from PPTs presentations, to sharing published documents, to visit successful demonstration interventions

Key principles: creation of ownership; building on local champions and engaging local decision makers for immediate institutionalization of major changes

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Country Specific Advocacy Approach

- Starts with a Strong statement about the huge health Benefits of Long Birth Intervals and/or the adverse effects of short intervals
- Shows the country spacing realities using the country validated data (e.g. DHS data)
- Presents data from the country linking Birth Intervals and Newborn, infant, child, under five mortality - to highlight child health problems associated with short birth Intervals
- Presents the Major New Findings from the USAID sponsored studies to highlight what the country could benefit by spacing longer women Birth Intervals
- Conclude with Strategies that could help couples space Births

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Overall Strategy: Combining Tailored Advocacy Interventions with Well Selected service Delivery Activities

The Service Delivery Component Focuses on WHO recommendations:
-**Audience**: providers of child health services: newborn care, immunization, growth monitoring and nutrition clinic, facility based IMCI, community IMCI

- **Content**: accurate and complete information about effects of HTPS on child health using country good data, regional data and new findings from the USAID sponsored six studies and WHO recommendation for Spacing

-**Methodology**: evidence based approach using various methods & channels; from PPTs presentations, to sharing published documents, to visit successful demonstration interventions or projects

Key principles: creation of ownership by building earlier on local champions and engaging local decision makers for immediate institutionalization of the major changes

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Institutionalization and Operationalization of the integration Strategy

- Integration within the country Child Health (PHC) Policy and Strategy guidelines (norms, protocols and standards)
- Integration in the country's Child Health tools and approaches for each target essential child health activities
- Integration to the training curriculum, supervision/ monitoring guides and other management materials for each of the essential child health activities
-
- Selected essential child health and maternal health activities include: *Antenatal care, Post-Partum Care, Immunization services, Growth Monitoring and nutrition clinic, Facility based-IMCI, Community IMCI, Emergency Visit at clinic for baby*

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Format of the Methodological guide for effective integration of Birth Spacing in child health activities

Selected New born and child health activities	Step in the newborn/child health caring process (1)	Assessment of mothers/couples' FP status and knowledge about Birth Spacing (2)	Information/Education to address the identified BS knowledge gaps and weaknesses (3)	Suggestions and advices to providers using this guide (4)
Postnatal Care (1)				
(Well baby Clinic) Immunization Nutrition clinic (2)				
Facility-Based IMCI (3)				
Community IMCI (4)				
Emergency Visit(5)				

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Enabling environment for a successful Integration: the Case of Rwanda

- Readily available quality and complete data from the 2005 country DHS for baseline and for planning purpose
- Functional PHC activities with constantly increasing performance for the essential MCH package in which the new HPS interventions will be integrated *(notice: 68.1% of pregnant women had 2-3 prenatal visits and 75.2% of children 12-23 completed their vaccinations)*
- Interested and opened powerful public officials organized with partners in various management and leadership functional structures
- Basics strong and strategic representation in country with a good reputation and high technical and leadership credibility to influence political and strategic decisions

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Enabling environment for a successful Integration : the Case of Rwanda

- A roster of interested local partners with excellent relationship with BASICS country representative
- Basics experience and expertise in engaging and coordinating partners work for common goals
- Appropriate tools and approaches reviewed and improved by internal and external experts from various organizations for quality assurance
- Enthusiast team both in country and at DC office which benefits from a solid internal and external support including USAID technical and political support.

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Conclusion

Integration of HTSP in Child Health Services is crucial to reinforcing Child Health Services

HTSP in child health contributes to expand the access and use of FP services by reducing the missed opportunities to educate women/couples in contraception for Birth Spacing

HTSP is an essential component of the Repositioning FP Initiative and should receive more attention and commitment from the FP program managers

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Health Timing and Spacing of Pregnancy Save Lives

Annex 2: Methodological Guide for Effective Integration of Birth Spacing into Newborn and Child Health Activities

Target Newborn and child health activities (services) (1)	Step in the newborn/child health management process (2)	Assessment of mother /couples FP status and Knowledge about BS (3)	Information/education to address the identified BS knowledge gaps and weaknesses (4)	Suggestions and advices to providers (5)
Antenatal Clinic/PMTCT a. At first ANC visit b. at subsequent repeat visits	At Health talk session [group] and/or at the individual counseling session after clinical examination	For the assessment questions ask about the women knowledge and attitude toward FP and BS. • Ask whether she ever use FP method of her choice • If yes -for how long? • If not - the main reasons? • Ask about her knowledge on Birth spacing effects • Ask if she knows her HIV status	Advice your client about the benefits of Birth Spacing. Insist on the three messages below in addition to the specific knowledge gaps identified during the assessment: **1. After a live birth couples can use effective FP method of their choice continuously for at least 24 months before trying to become pregnant again .but not more than five year after the last birth to prevent health problems and even death in mothers and babies and promote good health** **2. After a miscarriage or abortion couples can use an effective FP method of their choice for at least 6 months before trying to become pregnant again** **3. Adolescent girls should .use an effective FP method of their choice continuously until they are 18 years old before trying to become pregnant.** Insist on the specific benefits .of HTSP for HIV+ women/couples	As provider keep in mind that women/couples education for Birth Spacing should start as early as at teenage age and continue during and after pregnancy. Any training and supervision activity within MCH including PMTCT settings should continuously assess knowledge and skills related to this critical issue of HTSP-messages integration For HIV/AIDS-PMTCT counseling for HIV positive should insist ofn the role of HTSP in increasing the chances of survival of the infant

Target Newborn and child health activities (services) (1)	Step in the newborn/child health management process (2)	Assessment of mother /couples FP status and Knowledge about BS (3)	Information/education to address the identified BS knowledge gaps and weaknesses (4)	Suggestions and advices to providers (5)
Post-partum care a) Immediate postpartum (24 hours to 1st 7 days) b).Later postpartum (through 6 weeks) c) After six weeks to six months	At time of check up after delivery, at the most convenient time for the woman and whenever she returns for post partum visits	The assessment search for the attitude and perception as related to birth spacing: • Ask about the woman birth spacing history, perceptions and believes • Ask about the woman knowledge about the health benefits or risks associated with long or short birth interval • Ask about her spacing desire for next child if any Ask about her knowledge about modern contraceptive methods	The three messages in the box above will be delivered in addition to the specific knowledge gaps identified during the assessment.: Advise client about the lactational amenorrhea method.(LAM), immediate postpartum Talk about the 3 criteria for LAM: exclusively breastfeeding; menses has not returned; less than 6 months postpartum Advise addition of FP method of choice at 6 months (or) earlier if any of the three LAM criteria change Counsel on postpartum FP and HIV-Correct and consistent use of condoms and dual protection; healthy timing and spacing if future pregnancy desired	Most people think it is inappropriate to talk about FP to a postpartum woman who just .had a baby. But keep in mind that most women do not want another pregnancy after delivery. and postpartum women are still fecund and should be interested to FP. Help her understand well that she can be protected from another pregnancy for six months if she ispracticing LAM and breastfeeding exclusively if not the first ovulation with a chance of conception can occur at 6 weeks, after delivery, keeping in mind however, return to fertility time is not always predictable, if not practicing LAM

Target Newborn and child health activities (services) (1)	Step in the newborn/child health management process (2)	Assessment of mother /couples FP status and Knowledge about BS (3)	Information/education to address the identified BS knowledge gaps and weaknesses (4)	Suggestions and advices to providers (5)
[Well baby clinic] **Immunization services** Or **Growth Monitoring and Nutrition clinic**	**At the IEC first step** of the immunization or growth monitoring session which can be either integrated to the well baby package or offered separately and start by the information-Education-Communication activity	Assess what the mothers or child conveyors know about the benefits and advantages of Birth Spacing and the risks associated with short birth interval. It could be in a form of brainstorming and not a question response.	Provide information tailored to the needs identified at the assessment phase ensure that all attendees know enough about the benefits or risks associated to long or short birth spacing. The piece advices is the same that: 1. **After a live birth couples can use effective FP method of their choice continuously for at least 24 months before trying to become pregnant again .but not more than five year after the last birth to prevent health problems and even death in mothers and babies and promote good health** **2 After a miscarriage or abortion couples can use an effective FP method of their choice for at least 6 months before trying to become pregnant again** **3. Adolescent girls should .use an effective FP method of their choice continuously until they are 18 years old before trying to become pregnant.**	Various scenarios might occur here and require adaptation of the IEC/BCC approach. If the immunization in embedded in the well baby package, in addition to the mass communication approach a one-to-one dialogue can be added. I would allow to assess the mother FP status and to make sure that every woman who attended the immunization session know the health benefits or the risks associated with long or short birth interval.

Target Newborn and child health activities (services) (1)	Step in the newborn/child health management process (2)	Assessment of mother /couples FP status and Knowledge about BS (3)	Information/education to address the identified BS knowledge gaps and weaknesses (4)	Suggestions and advices to providers (5)
Facility Based IMCI clinic [*health center, general hospital, district hospital, private clinic]* - Three essential integrated steps: 1. Assessment and Classification 2. Treatment of sick child 3. Counsel mother (see column 2)	At **<u>Counsel the Mother</u>** step which already include most of following preventive advices but Birth Spacing : • Feeding recommendations • Feeding recommendation for HIV+ mothers • Counsel about feeding and breastfeeding • Feeding advices for the HIV confirmed • Counsel the mother about her own health • **Advise mother about benefits of longer birth spacing and dangers of short birth interval** • Advise mother about when to return	Questions will be directed to assess mother's FP status and knowledge .of benefits and risks of timing and spacing of pregnancies. • Ask whether the mother is using effective FP method of her choice, • Ask for how long mother is using FP method • Ask for how long mother intend to wait before trying to become pregnant again • Ask about any difficulties and constraints to access FP method • Ask about her knowledge and perception of Birth Spacing	Advise Mother and tailor the educational messages to her specific current situation as resulted from the assessment. **(a) If the mother is not currently using any effective contraceptive method:** • *explain the .benefits of family planning and healthy timing and spacing of pregnancies for her health, her child, family and community health,* • *.discuss the risks . when pregnancies are too close (less than 24 months from the last live birth to the next pregnanc).* • **(b) If the Mother is currently using FP method of her choice:** • emphasize the benefits of HTSP . and encourage her to follow recommendations from the three key messages above .Give her another appoint if appropriate to cover more essential topic such as the nutrition/feeding and birth spacing.	Remember that the counseling to mother step is the third step after (1) the assessment and classification of the sick child and (2) the treatment of the child. You may have shortage of time to counsel mother in all important issues related to her child health and her health. Select the priority topic most likely related to the current health condition of the sick child and her FP status. If she is not using any method, it becomes urgent to provide her will all needed information to understand well the risk associated with short Birth Interval.

Target Newborn and child health activities (services) (1)	Step in the newborn/child health management process (2)	Assessment of mother /couples FP status and Knowledge about BS (3)	Information/education to address the identified BS knowledge gaps and weaknesses (4)	Suggestions and advices to providers (5)
Community IMCI *[Health Post, Community health infrastructure /health hut]* Three essential integrated step (same as above)	**Same as above** As a community worker your counseling step may occur immediately after the assessment and classification of the child sickness. If you are not allowed to prescribe you may have to refer the client to where she can obtain the service.	**Same as above** Think about referring the mother to the appropriate health facility for questions and needs that you cannot satisfy	**Same as above** Your counsel, suggestions and assistance may include referral to the appropriate health facility where the mother can get the information and education needed *If the assessment reveals serious BS knowledge gaps and/or deficit in FP method use provide clients with IEC/BCC materials.* *You always should get back to your supervisor for additional information, educational materials, and support whenever necessary.*	The providers at community level (Community Health Workers) should have more time and could even organize a specific educational session on Birth Spacing.
Emergency visit at the clinic for baby	**At Counsel the Mother step** request for an appointment for an extended IEC/BCC special session.	If possible initiate the dialogue and run a rapid assessment of the woman birth spacing pattern or desire to better prepare the appointment requested	Based on the initial short assessment start preparing orienting the major aspects to cover during the requested IEC/BCC meeting This counseling focuses on mother contribution to administering the treatment and ways to mitigate the danger signs and symptoms identified	Kip in mind that at an emergency visit mothers are mostly interested in her child health. Any suggestions and advices must be first somehow related to her priority interest and concern.

Annex 3: Framework for Monitoring and evaluation at country level of the HTSP integration into routine newborn and child health

Key focus areas of interest	HTSP integration selected indicators	Definition proposed	Desired Output-performance level	Expected impact (outcomes)	Sources of information	Data collection techniques *(& reporting)*	Frequency
Integrated or isolate Materials (Policy, protocols, curriculum, guidelines ..) developed/adapted for HTSP integration to routine essential newborn and child health programs	# and type of integrated or isolate materials developed/adapted in use for HTSP integration to NCH activities	Curriculum, policy document, guidelines and jobs aids integrated or isolated elaborated to promote the HSTP integration to NCH	At least the generic PPT Advocacy tool, the training Manuel, the methodological guide and the supervisory check least be adapted and used	Enabling environment improved with HTSP Policies and protocols and guide lines available and being used for integration of HTSP into child health programs	records from MOH facilities and offices	Review of existing g reports and records	Annually
Knowledge generation among target beneficiaries (mostly child bearing women 15-29 years old) through conference, media campaign and social mobilization, provider-client interaction	Percentage of target child bearing women NCH clients knowledgeable about the benefits of HTSP (at service delivery sites)	Proportion of target child bearing women NCH clients who know the health benefits for the mothers and children of 3-5 years birth-birth interval, the health risks of shorter birth-birth interval <2 years and early pregnancy <18years old	At least 80% of child bearing women NCH clients involved	Increased in demand for FP for Birth Spacing and longer stay in the of FP users	List of target child bearing women client of NCH at Health facilities of administrative authority files	In-depth interview of selected child bearing women NCH clients randomly selected from the lists	Annually

Key focus areas of interest	HTSP integration selected indicators	Definition proposed	Desired Output-performance level	Expected impact (outcomes)	Sources of information	Data collection techniques *(& reporting)*	Frequency
Building Capacity of newborn and child health service providers through training, supervision, coaching	Percentage of target newborn and child health providers trained able to promote use the 3 key educational messages and the HTSP materials developed to promote HTSP integration to child health activities	Proportion of NCH providers who know the 3 key HTSP educational messages, can use the PPTs advocacy presentation and the methodological guide for effective integration of HTSP into NCH services	At least 80% of trained providers	Increased quality HTSP services	Reports from training, form supervision and facility periodic reports	Compilation of data from training & supervision reports Compilation routine data	Quarterly
Increasing length of stay in the FP program of child bearing women NCH client and FP users	Percentage of FP users with optimal length of stay in the FP program (at least 2 years)	Proportion of women among FP users who are continuously using their methods of choice for at least 2 for Birth Spacing	At least 80% of child bearing women NCH client within each NCH facility	Increased in birth spacing pattern in the target community	Routine data collected at FP service delivery sites & DHS study	Routine data from periodic report and Population based studies of FP	Quarterly and every five years

Annex 4: Questionnaires for Facility Level Directors, Health Providers, and Clients Interviews

QUESTIONNAIRE CENTRE DE SANTE-HOPITAL (A adresser au Titulaire/ Médecin Directeur)
Questionnaire for the Director of the Hospital or Head of Health Center

FOSA: AGREE PUBLIC
CELLULE : SECTEUR:
DISTRCIT: PROVINCE :

FONCTION DE LA PERSONNE INTERVIEWEE :

POPULATION DE LA ZONE DE RAYONNEMENT :
FEMMES EN AGE DE PROCREER :
ENFANTS DE MOINS DE 5 ANS :

PARTENAIRES : en PF :……
PCIME : ……
SONU :……
VIH/SIDA : …….

PERSONNES FORMEES SUR L'ESPACEMENT DES NAISNCES :

- NOMBRE : ……. En PCIME clinique
- NOMBRE : …….. PF (OJT OU AUTRES)
- NOMBRE : …….. SONU
- NOMBRE :…….. Autres (à préciser)

Existent-elles les femmes venant de passer plus de 2 ans sous contraception ? Oui non

a. Si oui, Combien de femmes enroulées entre Février 2006?
b. Combien de ces femmes continuent l les méthodes contraceptives ?
c. Pourcentage des femmes protégées au moins pendant 2 ans :
d. Expliquez ce pourcentage :

Selon vous, l'espacement idéal de naissances a rencontrées de succès dans votre zone ? OUI NON

Si oui, pourquoi ?
Si non, Pourquoi

QUESTIONNAIRE POUR PRESTATAIRE FORME
Questionnaire for the trained provider at the Health Center

LA FONCTION DE LA PERSONNE INTERVIEWEE :

1. Est ce que vous avez reçu la formation /information sur l'espacement des naissances? Oui Non

   Si oui,
   a. dans quel type de formation, avez-vous appris l'espacement idéal des naissances ?
   - PCIME
   - PF
   - Sonu
   - Autres : à préciser :…….

   b. Quand a eu lieu cette formation/information ?

2. Quel est l'intervalle recommandé de l'espacement des naissances ?

3. Quels sont les messages clés à ne pas oublier pendant la séance éducative sur l'espacement des naissances ?

4. Dans quelles activités actuelles de sante où vous diffuser l'information sur l'espacement des naissances ?

5. Existent-elles d'autres opportunités, selon vous, où nous pouvons donner des informations sur l'espacement de naissances ?

6. Combien de personnes avez-vous sensibilisé sur l'espacement idéal des grossesses de Novembre 2006 a la fin du mois de Février 2009?

7. Est-ce que vous avez des outils de gestion de l'espacement des naissances ? Oui Non

   Si oui, montrez-les ?

8. Est-ce que les clients adhérent facilement a 'approche espacement des naissances ? Oui Non

   Expliquez ?

9. Est-ce que les hommes sont impliqués à l'approche espacement des naissances idéal ? OUI NON
Si non, pourqui selon vous ?

10. Recevez-vous des supervisions régulières ? Oui Non

- Si oui a centre de sante, de l'hôpital combien après la formation ……
  du niveau central combien après la formation ……

- Si oui a hôpital, du niveau central combien après la formation ……

- Les supervisions du partenaire :

- Sinon, pourquoi ? (QUESTION **AUX SUPERVISEURS**)

11. Quels sont les problèmes /barrières rencontrés durant les séances éducatives sur l'espacement des naissances ?

12. Existent-ils des éléments qui ont contribuée à la réussite l'approche espacement idéal ? OUI NON

    Si oui, citez les ?

13. Quelles sont vos innovations pour l'atteinte des objectifs de l'espacement des naissances ?

    Citez-les s'il en a ?

QUESTIONNAIRE CLIENTS (INTERVIEW A LA SORTIE)

Client Exit Interview Questionnaire

FOSA : _____

1. Quel âge avez-vous?

2. Quelle est votre niveau d'instruction ?
   a. Analphabete
   b. Niveau primaire
   c. Niveau secondaire
   d. Niveau universitaire

3. Quel est le service que vous êtes venue consultée?

☐ CPN/PTME ☐ Maternite ☐ Family Planning ☐ Consultation postnatale

☐ Réhabilitation nutritionnelle ☐ Vaccination ☐ Consultation enfants ☐ Autres

4. Est-ce que vous avez d'enfants ? ☐ Oui ☐ Non
   a. Si oui combien d'enfants ?
   b. Quels sont les âges des vos enfants ?

5. Est ce que le prestataire vous a parlé de l'espacement des naissances ? ☐ Oui ☐ Non
   Si oui,

   Quel est l'intervalle pour un espacement de naissances que le prestataire vous a expliqué ?

   a. Quels sont les avantages pour un espacement de naissances que le prestataire vous a expliqué ?

6. Est-ce qu'il vous a expliqué que les méthodes contraceptives existes pour y arrivez ?
   ☐ Oui ☐ Non
   Si oui, lesquelles ?
   a.
   b.
   c.
   d.

7. Est que l'information en rapport avec l'espacement de naissances est nécessaire pour vous ?
   ☐ Oui ☐ Non

   Expliquez votre réponse ?

8. Utilisez-vous l'approche espacement idéal de naissances dans votre foyer ? ☐ Oui ☐Non
   a. Si oui, comment y arriverait-elle ?

b. Est-ce que votre mari vous aide ? Expliquez votre réponse.

9. Existent-elles-des femmes de votre agglomération qui utilisent l'espacement des naissances ?
   ☐ Oui ☐ Non

   Si oui, quels sont bénéfices que ces femmes tirées de cette approche ?

10. Pourriez-vous conseiller à vos amies à faire l'espacement des naissances ?
    ☐ Oui ☐ Non

    Expliquez votre réponse ?

11. Pensez vous que les méthodes contraceptives sont disponibles au centre de sante/ hôpital ?

    Expliquez votre réponse ?

Annex 5: Facility Data Collection

District	Date	Health Facility	
		Group I	Group II
RUHANGO	3/25/2009	Ruhango Health Center	Mbuye Health Center
		Karambi Health Center	Kigoma Health Center
		Gitwe District Hospital	
NYARUGURU	3/26/2009	Nyabimata Health Center	Kibeho Health Center
		Muganza Health Center	Maraba Health Center
			Munini District Hospital
NYANZA	3/27/2009	Nyanza Health Center	Kibirizi Health Center
		Nyanza District Hospital	Cyaratsi Health Center
RWAMAGANA	3/30/2009	Rubona Health Center	Rwamagana District Hospital
		Nzige Health Center	Rwamagana Health Center
			Ruhunda Health Center
KIREHE	3/31/2009	Kirehe Health Center	Gashongora Health Center
		Kirehe District Hospital	Gahara Health Center
		Rusumo Health Center	
RULINDO	4/1/2009	Kinihira Health Center	Rutongo District Hospital
		Tumba Health Center	Remera Mbogo Health Center
			Murambi Health Center

Annex 6: In-depth Interviews

Central Level:

Organization/ Institution	Interviewee	Title/Capacity
MOH	Dr Fidele Ngabo	Coordinator/MCH Task Force
MOH	Dr Denise Ilibagiza	Child health officer / MOH/MCH Task Force
MOH	Dr. Anicet Nzabonimpa	Coordinator HIV/FP integration/ MCH Taskforce
MOH	Dr Ferdinand Bikorimana	UNFPA/ Family Planning/ MCH Task Force
CAPACITY Project	Dr William Twahirwa	FP Point Person
CAPACITY Project	Dr Andre Koalaga	FP Senior Technical Advisor/MCH Task Force
Twubakane Project	Suzanne Mukakabanda	Reproductive Health Coordinator

Health Facility Interviews:

Organization/Institution	Interviewee
Hospital	Director
Hospital	Head of Maternity
Hospital	IMCI Supervisor
Hospital	Family Planning Coordinator
Health Center	Head of the Health Center
Health Center	Head of Maternity
Health Center	Head of IMCI
Health Center	Family Planning Provider
Health Center	At least FOUR clients exiting from Prenatal or PMTCT Counseling, Family Planning Counseling, IMCI Consultations, or Maternity Services