

# Postpartum Family Planning for Healthy Pregnancy Outcomes

## A Training Manual

February 2009



**USAID**  
FROM THE AMERICAN PEOPLE





***What is ESD?***

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

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# **Postpartum Family Planning for Healthy Pregnancy Outcomes: A Training Manual**

**The Extending Service Delivery (ESD) Project  
February 2009**



## Foreword

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This Manual provides material to conduct a comprehensive two-day training for facility-based health workers at the primary health care/community level facilities on providing community-based postpartum family planning education, counseling and referral that enables women and couples to use family planning for Healthy Timing and Spacing of Pregnancy (HTSP).

The Manual addresses the following:

- The importance of the postpartum period;
- Benefits of HTSP for postpartum women;
- Postpartum family planning; and
- Postpartum family planning counseling and education for HTSP.

Participatory training methodologies are used in this manual. Under each topic, key information for the trainer is provided, as well as a training activity to promote participant learning and skills development for improved community-based postpartum care that includes family planning and HTSP.

## Acknowledgements

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Finally, we thank the health care providers who participated in the training and shared their insights and suggestions. Their contributions helped to make the training more responsive to the needs of nurses, midwives and other providers working at the community level.

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## List of Acronyms

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AIDS	Acquired Immuno-Deficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
CBPP FP	Community-Based postpartum Family Planning
CHW	Community Health Worker
FP	Family Planning
HIV	Human Immunodeficiency Virus
HTSP	Healthy Timing and Spacing of Pregnancy
IUD	Intrauterine Device
LAM	Lactational Amenorrhea Method
LAPM	Long Acting and Permanent Methods
MCH	Maternal Child Health
MTCT	Mother-to-Child Transmission
PMTCT	Preventing Mother-to-Child Transmission
PP	Postpartum
PPFP	Postpartum Family Planning
RH	Reproductive Health
STI	Sexually Transmitted Infection

## Introduction and Overview

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*Postpartum Family Planning for Healthy Pregnancy Outcomes: A Training Manual* provides information and guidance on how to conduct a two-day training for primary health facility-based health workers including health supervisors, nurses, midwives, clinical officers, health assistants and outreach workers. (To maximize learning, participants should already have a basic understanding of and experience with the delivery of reproductive health and family planning services, so as to be better able to provide information, education and counseling to postpartum women.)

This training is intended to promote positive health outcomes for mothers, newborns and infants by improving health workers' skills in providing postpartum family planning information, education and counseling and increasing postpartum women's access to all family planning methods and services so that couples can achieve Healthy Timing and Spacing of Pregnancy (HTSP). This manual can be used to train health workers in the public, NGO and/or private sector.

The overall goal of training is to improve the knowledge and skills of facility-based health care workers to provide information, education, and counseling to women and their families on:

- the health and social benefits of healthy timing and spacing of pregnancy (HTSP); and
- the use of family planning and contraceptives in the postpartum period to achieve HTSP.

Training objectives include the following:

1. Participants will demonstrate improved knowledge about the benefits of HTSP.
2. Participants will be able to educate postpartum women on the benefits of HTSP and family planning based on their breastfeeding status, their reproductive intentions and desired family size.
3. Participants will be able to recommend appropriate postpartum contraceptive methods to postpartum women, including methods for breastfeeding women and the most appropriate time to initiate their use.

In this guide, the focus is on the delay of first pregnancy until after the age of 18 and spacing of subsequent pregnancies. USAID is reviewing the evidence on late age and high parity pregnancies and adverse outcomes. When the review is completed, specific messages will be developed for high parity women and women over the age of 35. Until then, the guide urges providers to discuss fertility intentions with all clients, and for high parity or older women.

Participatory training methodologies are used in this manual. As the name suggests, participatory training promotes the active involvement of participants. The role of the trainer is to guide the participants through the learning process; this goes beyond simply providing information. Training techniques used in this manual are designed to take advantage of each participant's knowledge and his or her abilities, ideas, skills and experiences that are invaluable to group learning. In addition, a variety of learning methods such as audio-visual aids, lectures, brainstorming, group discussions, case studies and role-plays are used to establish an energetic and positive learning environment that fully engages participants and facilitates lasting learning.

In developing this manual, ESD has utilized and adapted the work of various organizations including:

- *Family Planning: A Global Handbook for Providers* (WHO/USAID)

- *Postpartum Care of the Mother and Newborn: A Practical Guide* (WHO)
- *Medical Eligibility Criteria for Contraceptive Use* (3rd ed., WHO)
- *Sexual and Reproductive Health of Women Living with HIV/AIDS* (WHO and the United Nations Population Fund)
- *Comprehensive Reproductive Health and Family Planning Training Curriculum* (Pathfinder International)
- Module on family planning for postpartum women (ACCESS FP)
- Original research supported by CATALYST and ESD

The information and evidence-based practices from these organizations are presented here in simple language and in the format that is most appropriate for providers who work in primary level health care facilities.

## **USING THE MANUAL**

Six hours of training are suggested for each day, with adequate time for breaks as well as regular housekeeping and wrap-up activities. Training time is broken into 90-minute activities. Each activity includes the following:

- Learning objective(s)
- Advance preparation
- Required materials
- Activities and methodology
- Key messages
- Background information on the subject
- Handouts

Where possible, training should be conducted in the language that participants are most comfortable in speaking. To maintain the quality of the training there should be no more than 25 participants per training event.

A variety of learning methods are used, including:

### ***Lecture with Visual Aids***

This method presents training content both orally and visually. PowerPoint and/or transparencies may be used to present content when the equipment is available and there is a dependable supply of electricity.

Other visual methods include the use of whiteboard, blackboard, or flip charts.

### ***Brainstorming***

The main purpose of brainstorming is to generate an extensive list of ideas, thoughts or alternative solutions on a specific topic or problem. This technique allows the wealth of life and work experience to be shared with the group. It is a highly effective way for adults to learn by allowing many ideas to be shared in a short period of time. It stimulates thought and creativity and is often used to start group discussions.

### ***Case Studies***

Case studies allow trainees to apply what they have learned to "real life" situations. Case studies are used primarily to strengthen knowledge, problem-solving and clinical decision-making skills.

Typically, participants read and answer questions on a case study in writing or during a group discussion.

### ***Checklists***

Checklists are competency-based instruments that assess and evaluate the performance of clinical skills or other observable behaviors such as counseling or group education. Checklists focus on key steps or tasks of a procedure or activity.

### ***Handouts***

Handouts are printed materials with information relevant to a presentation. They can be copies of an oral presentation, or may be supplementary information to the subject being discussed.

### ***Role Plays***

Role plays are an interactive method where participants act out roles in skits that are related to the learning objective(s). An advantage of this approach is that participants can experience a common situation without having to take any personal risk. Role plays allow participants to develop an understanding of others' perspectives and encourages individuals to work together to analyze situations and develop solutions. Participants gain insights into challenges and build their confidence to address situations that they may encounter.

## **CREATING A POSITIVE LEARNING ENVIRONMENT**

An effective trainer creates a positive learning environment climate through good planning and preparation. The following suggestions will make the training more effective and enjoyable for both participants and trainer(s).

Participants are adult learners who:

- need learning to be relevant to their experiences and situations;
- are more motivated to learn if they believe the training is relevant;
- prefer participation and active involvement in the learning process;
- enjoy a variety of learning experiences;
- need positive feedback;
- have personal concerns that may need to be addressed;
- need a safe atmosphere;
- must be recognized as individuals with unique backgrounds, skills and experiences; and
- have high expectations for themselves and their trainer.

A positive learning climate requires the active involvement of learners. Allow participants to opportunity to give input on schedules, activities and other events. Invite them to ask questions and give feedback. Encourage brainstorming and discussions. Plan for hands-on work, group and individual projects and other participatory activities.

Positive feedback to participants is very important. Positive feedback can be given by:

- praising participants (either publicly or privately);
- responding positively to questions;
- acknowledging participant skills;
- reinforcing participant progress in achieving learning objectives;
- respecting participants as individuals; and
- facilitating information sharing among participants.

## **ASSESSING THE TRAINING**

The manual also includes sample tools in the appendix, such as a pre-test, post-test, and evaluation forms which will assist the trainer to achieve the training objectives and to assess the need for any additional training.

### ***Pre- and Post-test***

These tests help both trainer and participant assess their learning. Trainers should administer the pre-test in the first session of the training, and give the post-test is after training is complete.

A pre-test gives the trainer a better understanding of the participants' baseline knowledge about community-based postpartum family planning. Participant strengths and weaknesses can be assessed and the training can be adjusted as needed. The post-test gauges how well trainees understood the content.

### ***Evaluation forms***

Evaluation forms can be given to participants at the end of each day or at the end of the training to assess their overall satisfaction and identify areas of strengths and weakness for the trainer.

## **EQUIPMENT AND SUPPLIES**

Arrangements should be made well in advance of the training to secure the necessary materials and supplies and arrange for their transport to the training site as needed.

Suggested equipment for the training includes the following:

- Two flip charts with an easel
- Different colored markers
- Laptop computer and projection monitor (LCD) compatible with computer (where available)  
OR
- Overhead projector and transparencies, or chalkboard/whiteboard
- Extension cord
- Masking tape for posting flip chart if the flip chart is not the self adhesive type
- Note pads
- Pens and pencils
- Folders
- Certificates of Completion

## **PREPARING FOR THE TRAINING**

Prior to the training, the trainer should:

- Prepare presentations
- Where appropriate, confirm guest speakers and presenters
- Review the training goals, learning objectives, schedule, sessions and reference material
- Review the pretest and posttest and make copies for each participant

- Make copies of relevant handouts, case studies, role-plays, etc. to be distributed in the training
- Check all audio-visual equipment
- Check training venue for set up, lights, air conditioning or heat, etc
- Ensure arrangements have been made for breaks, lunch, transportation, accommodation, allowances, etc
- Prepare participant packets, including notebooks, pencils/pens, handouts, etc
- Prepare registration sheets

## Suggested Training Agenda

DAY 1		DAY 2	
Session and Time	Content	Session and Time	Content
<b>1</b> 8:30 - 10:00	Welcome Pretest	<b>5</b> 8:30 - 10:00	Postpartum FP for HTSP
10:00 - 10:15	BREAK	10:00 - 10:15	BREAK
<b>2</b> 10:15 - 11:45	The Importance of the Postpartum Period	<b>6</b> 10:15 - 11:45	Postpartum FP/HTSP: Involving Men
11:45 - 12:45	LUNCH	11:45 - 12:45	LUNCH
<b>3</b> 12:45 - 2:15	Healthy Timing and Spacing of Pregnancy (HTSP)	<b>7</b> 12:45 - 2:15	Action Planning
2:15 - 2:30	BREAK	2:15 - 2:30	BREAK
<b>4</b> 2:30 - 4:00	Postpartum Family Planning	<b>8</b> 2:30 - 3:30	Posttest Evaluation Closing

**Summary of Session Plans  
Day 1–Morning**

<b>Session</b>	<b>Time</b>	<b>Session Title</b>	<b>Objectives and Activities</b>	<b>Materials</b>	<b>Advance Preparation</b>
1	90 min	Introduction to the Training	<ol style="list-style-type: none"> <li>1. Create positive climate for learning</li> <li>2. Orient participants to goal and outcomes of training               <ul style="list-style-type: none"> <li>- Welcome participants</li> <li>- Provide overview of training</li> <li>- Set ground rules</li> <li>- Assess expectations</li> <li>- Administer pre-test</li> </ul> </li> </ol>	<ul style="list-style-type: none"> <li>• Daily registration form</li> <li>• Participant materials</li> <li>• Name tags</li> <li>• Flip chart</li> <li>• Markers</li> <li>• Copies of the agenda</li> <li>• Flipchart of day's agenda</li> <li>• Copies of Tool #1 (Pretest)</li> </ul>	<ul style="list-style-type: none"> <li>• Prepare participant materials</li> <li>• Address training logistics</li> <li>• Photocopy agenda and pretest</li> <li>• Write the day's agenda on a flipchart</li> </ul>
<b>BREAK</b>					
2	90 min	The Importance of the Postpartum Period	<ol style="list-style-type: none"> <li>1. Improve understanding of health risks during postpartum period</li> <li>2. Understand relevance of providing FP information and services to postpartum women</li> <li>3. Define ways to involve the community               <ul style="list-style-type: none"> <li>- Presentation on postpartum period</li> <li>- Brainstorm</li> <li>- Small group work and discussion</li> </ul> </li> </ol>	<ul style="list-style-type: none"> <li>• Flip chart and markers</li> <li>• PowerPoint presentation or transparencies</li> </ul>	<ul style="list-style-type: none"> <li>• Prepare flip charts for posting</li> </ul>
<b>LUNCH</b>					

**Summary of Session Plan  
Day 1–Afternoon**

<b>Session</b>	<b>Time</b>	<b>Session Title</b>	<b>Objectives and Activities</b>	<b>Materials</b>	<b>Advance Preparation</b>
3	90 min	Healthy Timing and Spacing of Pregnancy (HTSP)	<ol style="list-style-type: none"> <li>1. Understand what HTSP means</li> <li>2. Understand the benefits of HTSP</li> <li>3. Understand how HTSP is an important component of postpartum services               <ul style="list-style-type: none"> <li>- Presentation on HTSP</li> <li>- Small group work and discussion</li> <li>- Role plays</li> </ul> </li> </ol>	<ul style="list-style-type: none"> <li>• Flip chart and markers</li> <li>• PowerPoint or transparencies</li> <li>• Handout #1 WHO Policy Brief</li> <li>• Handout #2 HTSP graphs</li> <li>• Handout #3 HTSP 101</li> <li>• Handout #4 HTSP Messages</li> <li>• Handout #5 Benefits of HTSP and Risks of Not Practicing HTSP</li> <li>• Handout #6 The Facts</li> <li>• Adolescent Mortality: An Overlooked Crisis</li> </ul>	<ul style="list-style-type: none"> <li>• Make copies of Handouts</li> <li>• Write up role plays on flip chart paper and post</li> <li>• Post HTSP messages</li> <li>• Collect local IEC materials on maternal and child health and family planning</li> </ul>
<b>BREAK</b>					
4	90 min	Postpartum Family Planning	<ol style="list-style-type: none"> <li>1. Describe appropriate FP methods for postpartum women</li> <li>2. Recommend appropriate FP for postpartum women, based on her breastfeeding status</li> <li>3. Understand and apply concepts of Lactational Amenorrhea Method (LAM)               <ul style="list-style-type: none"> <li>- Presentation on FP</li> <li>- Card match game</li> <li>- Case study</li> </ul> </li> </ol>	<ul style="list-style-type: none"> <li>• Flip chart and markers</li> <li>• PowerPoint or transparencies</li> <li>• Handout #7 Contraceptives for postpartum Women</li> <li>• Handout #8 When to Initiate Contraceptive Use for postpartum women</li> <li>• Handout #9 Long Acting and Permanent Methods</li> <li>• Handout #10 Lactational Amenorrhea Method</li> </ul>	<ul style="list-style-type: none"> <li>• Make copies of handouts</li> <li>• Write up case study on flip chart paper and post</li> <li>• Prepare for card match game.</li> </ul>

**Summary of Session Plan  
Day 2–Morning**

<b>Session</b>	<b>Time</b>	<b>Session Title</b>	<b>Objectives and Activities</b>	<b>Materials</b>	<b>Advance Preparation</b>
5	90 min	Postpartum Family Planning for HTSP	1. Educate and counsel postpartum women on using FP for HTSP <ul style="list-style-type: none"> <li>- Presentation</li> <li>- Role play</li> </ul>	<ul style="list-style-type: none"> <li>• Flip chart and markers</li> <li>• PowerPoint or transparencies</li> <li>• Handout #11 GATHER for HTSP</li> <li>• Handout #12 What Makes FP Counseling Effective?</li> <li>• Handout #13 FP Counseling Strategies</li> <li>• Tool # 3 FP for HTSP Counseling Checklist</li> </ul>	<ul style="list-style-type: none"> <li>• Print out handouts</li> <li>• Write up role plays on flip chart paper and post</li> </ul>
<b>BREAK</b>					
6	90 min	Postpartum FP: Involving Men	By the end of the session, participants will <ul style="list-style-type: none"> <li>• Examine their own comfort level in counseling and communicating with men on postpartum FP</li> <li>• Discuss biases against and in favor of men</li> <li>• Articulate characteristics of effective providers of services to men</li> </ul>	<ul style="list-style-type: none"> <li>• Flip chart and markers</li> <li>• Power point presentation/transparencies</li> <li>• Handout 15#: Provider comfort when counseling men</li> </ul>	<ul style="list-style-type: none"> <li>• Copy handouts</li> </ul>
<b>LUNCH</b>					

**Summary of Session Plan  
Day 2–Afternoon**

<b>Session</b>	<b>Time</b>	<b>Session Title</b>	<b>Objectives and Activities</b>	<b>Materials</b>	<b>Advance Preparation</b>
7	90 min	Action Planning	1. Develop action plans to apply learning to the workplace	<ul style="list-style-type: none"> <li>• Tool # 4 Action Planning Matrix</li> </ul>	<ul style="list-style-type: none"> <li>• Make copies of Action Planning Matrix</li> </ul>
<b>BREAK</b>					
8	60 min	Closing	<ol style="list-style-type: none"> <li>1. Administer posttest</li> <li>2. Administer evaluation</li> <li>3. Present certificates</li> </ol>	<ul style="list-style-type: none"> <li>• Copies of posttest</li> <li>• Copies of evaluation</li> <li>• Certificates of Completion for each participant</li> </ul>	<ul style="list-style-type: none"> <li>• Make copies of posttest and evaluation</li> <li>• Prepare certificates of completion for each participant</li> </ul>

## Session 1: Introduction to the Training

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### Session Objectives

- To create a positive climate for learning
- To orient participants to the goal and expected outcomes of the training



### Time

90 minutes



### Advance Preparation

- Prepare participant packets
- Photocopy the agenda and pretest for all participants.
- Set up the room, check logistics
- Write the daily agenda on a flipchart and post on the wall of the training room



### Materials and Handouts

- Daily registration form or sign in sheet
- Name tags
- Participant packets
- Flip chart, easel and markers
- Copies of the agenda for each participants
- Flipchart posted with the day's agenda
- Copies of the pretest for participants and trainers

### Training Activities

1. As participants enter, greet them, give them a name tag, have them fill in the registration form and distribute workshop packets
2. Formally open the training. This can be done by an invited guest such as a representative of the Ministry of Health, or a local community leader.
3. Welcome participants; explain the purpose of the training, and introduce the trainer(s).
4. Ask participants to introduce each other. You can do this by having the participants briefly state his/her name, worksite, and at least one thing s/he hopes to gain from the training. Record the participant expectations on a flipchart and post.
5. Provide an overview of the training by reviewing the training goal and objectives. Refer to the overall agenda and review with participants. Where possible, point out where the training will meet participant expectations or explain why this is not the case. Respond to any questions about the day or about the overall workshop
6. Distribute the pretest. Tell participants that this is a simple test designed to assess their existing knowledge and practices related to postpartum family planning and HTSP. Explain that it will help indicate areas where additional information and/or skills development may need to be addressed during the training.
7. Create a set of ground rules to which all agree. Explain that ground rules:
  - Allow all participants to benefit from the training
  - Ensure that everyone can participate openly
  - Create a stress-free learning environment

**Examples of ground rules include:**

- Arrive on time
- Come back from breaks on time
- Attend the entire day
- Start and end on time
- Keep side conversations to a minimum
- Speak one at a time
- Show respect for others
- Maintain confidentiality
- Turn off cell phones
- Be engaged in the training
- Have fun

Ask the participants to brainstorm about their expectations of how the group will work together during the training. Write these ideas on a flip chart and post.

8. Summarize key messages and wrap up. Invite participants to comment or ask questions.

**Key Messages for this Session**

- √ The purpose of this training is to improve the knowledge and skills of health workers to provide information, education and counseling to postpartum women and their families about the importance of healthy timing and spacing of pregnancy (HTSP) so as to help ensure improved outcomes for postpartum women and their babies.
- √ To practice HTSP, women and couples need to be able to use family planning methods. Improved use of HTSP and FP will lead to better health outcomes for women and their babies.
- √ Everyone in the training brings experiences and skills that are valuable to the training.
- √ The role of the trainer will be to provide up-to-date information and opportunities for skills development in postpartum family planning services and healthy timing and spacing of pregnancy.
- √ Participants will learn from the trainer and from each other through interactive sessions that include technical updates, discussions, role-playing, case studies and group work. Each session builds upon the previous one, so it is important to attend the entire two-day training.
- √ When participants return to their jobs, they will have the knowledge and skills to adopt a more holistic approach to clients that considers the socio-cultural and other factors that influence their reproductive health and family planning behaviors.

## Session 2: The Importance of the Postpartum Period

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### Session Objectives

By the end of this session, participants will:

- Improve their understanding of health risks during the postpartum period.
- Understand the relevance of providing FP information, education, counseling and services during postpartum care.
- Define ways to involve the community in postpartum care.



### Time

90 minutes



### Materials

- Flipchart and markers
- Power point presentation or transparencies
- Handout#1 ACCESS FP Counseling Schema



### Advance Preparation

1. Prepare three flipcharts on which you have clearly written the following information:

<b>Flipchart 1: Young Mothers</b>	<b>Flipchart 2: Postpartum Care and Family Planning</b>	<b>Flipchart 3: Unmet Need, Community Participation/ Involvement</b>
Why do young mothers face greater health risks?	What are the major goals of postpartum care?	Why is there unmet need for FP?
What are some possible reasons?	What are the advantages of including FP as part of postpartum care?	How can the community be better involved in addressing unmet need?
What are some ways to reduce risk?	When should FP be promoted during postpartum care?	What can providers do to facilitate community involvement in providing postpartum family planning?

2. Prepare and post three flip charts with the HTSP messages (below)

<b>For couples who desire a next pregnancy after a live birth</b>	<b>For couples who decide to have a child after a miscarriage or abortion</b>	<b>For adolescents</b>
For the health of the mother and the baby, wait at least 24 months, but not more than 5 years, before trying to become pregnant again.	For the health of the mother and the baby, wait at least six months before trying to become pregnant again.	For your health and your baby's health, wait until you are at least 18 years of age, before trying to become pregnant.
Consider using a family planning method of your choice during that time.	Consider using a family planning method of your choice during that time.	If you are sexually active, consider using a family planning method of your choice until you are 18 years old.

### **Training Activities**

1. *Presentation and discussion* (30 minutes)  
An Introduction to the Postpartum Period

2. *Brainstorm* (25 minutes)

- Why is the postpartum period such a unique and critical time in a woman's and newborn's life?
- Why is postpartum care so important?

Emphasize the following points:

- Women and newborns have a higher risk of becoming sick during the postpartum period.
- Women and newborns have a higher risk of dying during the postpartum period.
- Women under the age of 20 and their newborns are especially at risk of death or illness.

Refer briefly to the three HTSP messages you have posted. Explain that these will be discussed in more detail in the next session, especially in relation to postpartum care.

Distribute Handout #1, ACCESS FP's Programmatic Framework: PFP in an Integrated Context, and review with participants.

3. *Small group work and discussion* (30 minutes)

Divide the participants into three groups. Provide each group with a flip chart and markers. Ask each group to select a recorder, moderator and presenter.

- Group 1 will discuss Flip Chart #1
- Group 2 will discuss Flip Chart #2
- Group 3 will discuss Flip Chart #3

Allow groups 10 minutes to discuss and record their responses. Encourage them to refer to the HTSP messages and their handouts.

When the small groups are finished, have each group present their findings to the larger group. Invite other participants to comment or ask questions.

4. *Summary and wrap-up* (5 minutes)

Pose the following question:

What do you think are the benefits of providing family planning services to postpartum women?

Suggested responses may include:

- To reduce maternal mortality and morbidity
- To reduce infant mortality and morbidity
- To prevent unwanted pregnancies
- To prevent high risk pregnancies among younger and older mothers, where maternal and infant mortality is higher
- To reduce the incidence of miscarriage or abortion
- To allow women to space their pregnancies
- To reduce the number of cases of vertical transmission of HIV/AIDS (i.e. mother-to-child)



### **Key Messages for this Session**

- √ The postpartum period is a unique phase in the life of a woman and her newborn. It is a time of transition, adjustment and adaptation along with significant biological, social and psychological changes.
- √ The postpartum period starts from the first hour after delivery of a baby and placenta, and lasts until six weeks after delivery, when the body of the woman has largely returned to its non-pregnant state.
- √ The extended postpartum period is through the first year after a birth<sup>1</sup>.
- √ The extended postpartum period is a critical time for appropriate health interventions for women and babies, as the majority of maternal and infant deaths and illness occur during this period.
- √ A woman's ability to become pregnant is likely to return during the extended postpartum period. In general, a non-breastfeeding woman's fertility returns within 4 to 6 weeks, sometimes as early as 3 weeks postpartum.
- √ For the healthiest outcomes for mothers and babies, women and couples should wait 24 months after delivery before trying to become pregnant again by using an FP method of choice.
- √ Pregnancy is the leading cause of death among young women aged 15 - 19.
- √ Infants of adolescents aged 15 - 19 are at increased risk for death; infants of adolescent mothers are more likely to die before their first birthday than children of older mothers.

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<sup>1</sup> Includes immediate postpartum (first four to six hours as defined by WHO); later postpartum (six hours to six weeks as defined by WHO) and beyond six weeks through the first year. The extended postpartum period is important for postpartum family planning (PPFP).

## **THE POSTPARTUM PERIOD**

The postpartum period is a unique phase in the life of a woman and her newborn. It is a time of transition, adjustment and adaptation along with significant biological, social and psychological changes.

According to the World Health Organization (WHO) the postpartum period starts from the first hour after delivery of the placenta, and includes the first six weeks after delivery, when the body of the woman has largely returned to its non-pregnant state. Family planning programs discuss the extended postpartum period as being one year after delivery.

Family planning programs recognize the importance of providing FP to postpartum women, because it is during the extended postpartum when a woman's fertility returns, and where unmet need for FP is high.<sup>2</sup>

The postpartum period is also a period of risk for women and babies. WHO reports that over 60% of maternal deaths in developing countries occur during the postpartum period. Of these deaths, the majority are due to pregnancy-induced hypertension (PIH) and postpartum hemorrhage (PPH), which most often occur in the first day postpartum. Deaths from PPH and PIH occur within seven days of delivery, while deaths from sepsis occur in the second week after delivery.

There are more than 3.3 million stillbirths each year, and more than four million neonatal deaths. About half of the neonatal deaths take place within 72 hours of delivery. Most postpartum deaths occur in developing countries among women who lack access to skilled care during labor and delivery or in the immediate postpartum period. Nearly half of women in developing countries deliver without the help of skilled birth attendants, and less than a third receive any postpartum care.

WHO recommends that improved postpartum care is a long-term investment in the future health of women and their babies.

*(Here you may wish to provide information on postpartum maternal and infant mortality and morbidity in your country, region, province or district.)*

### **Components of Integrated Postpartum Care**

Postpartum care should actually begin during antenatal care. Providers can begin to educate and counsel women on what to they should expect and how they should care for themselves and their babies after delivery, because mothers and newborns have specific health needs during the postpartum period.

Mothers can experience bleeding, infection, high blood pressure, poor nutrition and depression during the postpartum period. The newborn, especially those who are born premature, can be susceptible to infection, respiratory problems, tetanus, cord infections, and other problems. Women should also be counseled about the importance of immediate and exclusive breastfeeding, return to fertility, future pregnancy intentions, healthy timing and spacing of pregnancy and family planning options.

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<sup>2</sup> Postpartum Family Planning Technical Consultation–Report Brief, ACCESS-FP 2006.

WHO recommends a schedule of postpartum visits that correspond to the times of greatest need for a mother and her infant. Women and their babies should receive postpartum care at six hours, six days, six weeks, and six months<sup>3</sup>. Although the timing of these visits is important, postpartum care must always remain flexible to the needs of the mother and the baby.

*(Here you may wish to discuss what practices are common in your country, region, province or district, compared to the WHO recommendations.)*

There is a range of important information and services that should be provided during both the antenatal and postpartum period. New research recommends that providers strengthen their efforts to educate and counsel postpartum women on Healthy Timing and Spacing of Pregnancy (HTSP) and how the use of family planning to space pregnancies can significantly contribute to improved health for both women and their babies.

USAID Technical Update No 5, *FP During the First Year Postpartum*,<sup>4</sup> suggests the following messages to guide health workers during home visits to pregnant and new mothers:

***During antenatal period***

- Importance of immediate and exclusive breastfeeding
- Fertility intentions
- LAM or other methods as reproductive intentions indicate
- Pregnancy spacing counseling for women who want another child

***During immediate postpartum (within the first week)***

- Exclusive breastfeeding
- Reproductive intentions
- Pregnancy spacing counseling for women who want another child
- LAM or other methods as reproductive intentions indicate
- Importance of postnatal care for the mother and newborn

***During postnatal care contact (within six weeks)***

- Exclusive breastfeeding
- Reproductive intentions
- Return to sexual activity
- Pregnancy spacing counseling for women who want another child
- LAM or other methods as reproductive intentions indicate
- Contraceptive options
- Importance of well-baby care

***Child health contacts during the first year***

- Exclusive breastfeeding through first six months, then breastfeeding with complementary feeding
- Reproductive intentions
- Pregnancy risk
- Pregnancy spacing counseling for women who want another child

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<sup>3</sup>WHO Technical Working Group Report on Safe Motherhood. Postpartum Care of the Mother and Newborn: a Practical Guide, WHO 1998.

<sup>4</sup>Technical Update No. 5: FP During the First Year Postpartum, Community Based Family Planning, USAID January 2008.

- LAM and transition to other methods as reproductive intentions indicate
- Contraceptive options
- Importance of well-baby care

This will be further discussed in upcoming sessions.

### **Family Planning as a Part of Postpartum Care**

Unmet need for family planning is common in many countries. (“Unmet need” means simply that a woman would like to use family planning to prevent or space a birth or avoid future pregnancies altogether, but is not currently using a method.)

Unmet need for spacing among postpartum women is very high. Ninety-five to 98% of postpartum women do not want another child within two years, yet only 40% are using a family planning method.

Improved use of family planning services in the postpartum period can help reduce maternal and infant illness and death, which consumes a vast proportion of health resources. Improved access to contraception will help women better delay, space and/or limit their pregnancies, which in turn will save lives and conserve resources that can be used to improve health care for all.

*(Here you may wish to include information about unmet need in your country, region, state, province, etc.)*

Increased use of family planning among postpartum women can significantly:

- reduce maternal mortality and morbidity;
- reduce infant mortality and morbidity;
- prevent risky or unwanted pregnancies;
- prevent pregnancy among younger and older women, when the risk of maternal and infant death is greatest;
- reduce the incidence of abortion, especially unsafe abortion, which causes 13 % of maternal mortality worldwide;
- allow women to space their pregnancies; and
- reduce the number of cases of vertical transmission of HIV/AIDS (i.e., mother-to-child).

### **Adolescent Women Have High Unmet Need**

Young women—especially young mothers and young married women—are less likely to use both family planning and antenatal and postnatal care services. This places them and their infants at particular risk for health issues.

- There is a high level of unmet need for family planning among adolescents and young women.
- Rates of contraceptive use tend to be lowest among adolescents and young women, particularly young married women.
- Young women are less likely to use antenatal and postpartum services where they can obtain important information and counseling on healthy pregnancy, childbirth and spacing.

- Young mothers aged 19 years and under and their babies are more likely to experience pregnancy related complications and illness such as pre-eclampsia, obstructed labor, fistula, premature birth or low birth weight, in part because they are physically immature.
- Young mothers are less likely to seek health care or are late in obtaining care when problems do occur, due to a range of psychosocial, cultural and economic constraints.
- Young married women may be more likely to experience several closely spaced pregnancies, which can negatively affect the health of both women and children.

Providing reproductive health and family planning information and services during postpartum and other care can help young women and their partners learn about the health benefits of FP and HTSP and contribute to the well-being of young mothers and their babies.

*(Here you may wish to present information on unmet need among young women 15 - 24, including birth rates, abortion, percentage of closely spaced births, etc.)*

### **Women Living with HIV Need FP Services**

There is evidence that many sexually active HIV positive women would like to prevent pregnancy or are undecided as to whether or not they want to have another baby. However, unmet need for family planning remains high among these women.

As access to prevention of mother to child transmission (PMTCT) programs is expanded, many women are learning about their HIV status during pregnancy. As the benefits of family planning extend to all women, regardless of their status, all postpartum women should be advised on healthy spacing of the next pregnancy, including postpartum women who are HIV positive.

Women, whether HIV positive or not, often have low levels of correct knowledge on the benefits of family planning. In addition, women with HIV may be reluctant to seek FP services because of stigma and discrimination. Discussing family planning options with postpartum HIV positive women as part of postpartum care may help them overcome these fears and concerns so as to avoid an unintended pregnancy and/or help ensure that their next pregnancy is a healthy one.

The needs of postpartum women with HIV will be discussed further in the training.

*(Here you may wish to provide information about women with HIV in your country, state, region, province or district.)*

### **Community Support for Postpartum FP**

Until recently, much emphasis has been placed on the use of antenatal care to address safe motherhood and child survival. Aspects of postpartum care should be—and often are—addressed as part of antenatal care. However, postpartum care is in itself an important step to ensure maternal and child health and should not be neglected. In addition, the integration of family planning information and services with postpartum care can add significant health benefits for women and children.

To be effective, postpartum programs need to be a collaborative effort with the community. Couples, parents, families (including men, whose importance is often overlooked) traditional care givers, service providers—all must work together to establish a continuum of care from pregnancy through the first year of the child's life.

Ensuring that health workers and community members have accurate information is an important element as a community works to reduce preventable disability and death in its women and children.

## Session 3: Healthy Timing and Spacing of Pregnancy (HTSP)

### Session Objectives

By the end of this session, participants will:

- Understand what HTSP means
- Understand the benefits of practicing HTSP
- Understand how HTSP is an important component of postpartum services



### Time

90 minutes



### Materials

- Flip chart and markers
- Power point presentation /transparencies
- HTSP Messages (posted on flip chart paper)
- Local IEC materials which are currently used for the promotion of maternal and child health and family planning.
- Handouts:
  - Handout #2 WHO Policy Brief on Pregnancy Spacing
  - Handout #3 The HTSP Messages
  - Handout #4 HTSP Graphs 1, 2, and 3
  - Handout #5 HTSP 101: Everything You Want to Know About Healthy Timing and Spacing of Pregnancy
  - Handout #6 Benefits of HTSP and Risks of Not Practicing HTSP
  - Handout #7 The Facts Adolescent Maternal Mortality: An Overlooked Crisis



### Advance Preparation

- Make copies of all handouts for each participant
- Write role plays (below) on flip chart paper and post
- Collect any local IEC materials that are used for educating women about maternal and child health and/or family planning.

<b>Role Play #1</b>	<b>Role Play #2</b>	<b>Role Play #3</b>
A 22-year-old woman had her baby a month ago. She brings the baby for a well-baby visit.	A sixteen year old woman is seen at the health center for a miscarriage. Her first child is eight months old.	A 35 year old woman has just delivered her fourth daughter. She has come today with her husband.

### Training Activities

1. *Presentation and Discussion on Healthy Timing and Spacing of Pregnancy (30 minutes)*

Be sure to address the following points:

- The WHO technical consultation on HTSP
- The technical experts' recommendations
- The benefits of HTSP, especially for postpartum women
- The HTSP messages
- Opportunities for integrating HTSP messages as part of other programs and services

Distribute the following Handouts:

- Handout #2 WHO Policy Brief on Pregnancy Spacing
- Handout #3 The HTSP Messages
- Handout #4 HTSP Graphs 1, 2, and 3
- Handout #5 HTSP 101: Everything You Want to Know About Healthy Timing and Spacing of Pregnancy

2. *Small group work and discussion* (30 minutes)

Divide participants into four groups.

Distribute the following Handouts:

- Handout #6: Benefits of HTSP and Risks of Not Practicing HTSP
- Handout #7: The Facts Adolescent Maternal Mortality: an Overlooked Crisis.

Briefly review the handouts.

Ask each group to address the following questions, keeping in mind the three HTSP messages:

- How do you think the HTSP messages will be perceived in the community?
- Who will support HTSP? Who might be against it?
- Are there any constraints to discussing HTSP as part of postpartum care? Why?
- What is needed to help women and men practice HTSP?
- What are some ways that you can promote HTSP as part of postpartum care?

Ask participants to record their responses on a flip chart and present their main findings to the group.

Post the flip charts.

3. *HTSP role plays* (25 minutes)

Ask for two volunteers to perform a role play.

Read Role Play #1:

**A 22-year-old woman had her baby a month ago. She brings the baby for a well-baby visit.**

Ask volunteers to act out this role play, using the information that has been presented on HTSP. Allow 5 - 7 minutes for the role play.

Ask the group the following questions:

- Was the explanation on HTSP sufficient? In what way?
- What else would you add?
- Were the time and place appropriate to discuss HTSP with the patient? In what way?
- What other opportunities might exist to discuss HTSP with this client? With other clients?

Now read out Role Play #2:

**A sixteen year old woman is seen at the health center for a miscarriage. Her first child is eight months old.**

Ask for two volunteers to perform this role play, and discuss, as above.

If time permits, you can ask the group to perform Role Play #3:

**A 35 year old woman has just delivered her fourth daughter. She has come today with her husband.**

3. *Summary and Wrap-up* (5 minutes)

Invite participants to ask questions or make comments.



**Key Messages for this Session**

- √ HTSP promotes improved health outcomes for mothers, newborns and infants through better pregnancy spacing.
- √ The use of a family planning method is essential to HTSP.
- √ HTSP information and education is important during the antenatal and postpartum period so that women, their families and communities can become more aware of the health and social benefits of using FP to space pregnancies.
- √ HTSP and FP can be easily integrated into a number of health and outreach services, especially as part of addressing desired family size, future pregnancy intentions, and options for pregnancy spacing and limiting.
- √ Providers should discuss fertility intentions and desired family size with all clients, and provide or refer for delay, spacing or limiting services, as appropriate.

## HTSP: Research and Recommendations

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

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

Over the past few years, the United States Agency for International Development (USAID) has sponsored a series of studies on pregnancy spacing and health outcomes. The research objective was to assess, from the best available evidence, the effects of pregnancy spacing on maternal, newborn and child health outcomes.

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

### Technical Consultation Recommendations to WHO<sup>7</sup>

#### ***Preamble***

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

#### ***Recommendation for spacing after a live birth***

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

#### ***Recommendation for spacing after a miscarriage or induced abortion***

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

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

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

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<sup>5</sup>WHO is reviewing the technical experts' recommendations and has requested additional analyses to address questions that arose at the 2005 meeting. WHO recommendations will be issued when their review has been completed.

<sup>6</sup> Report of a WHO Technical Consultation on Birth Spacing. World Health Organization, 2006.

<sup>7</sup> Ibid.

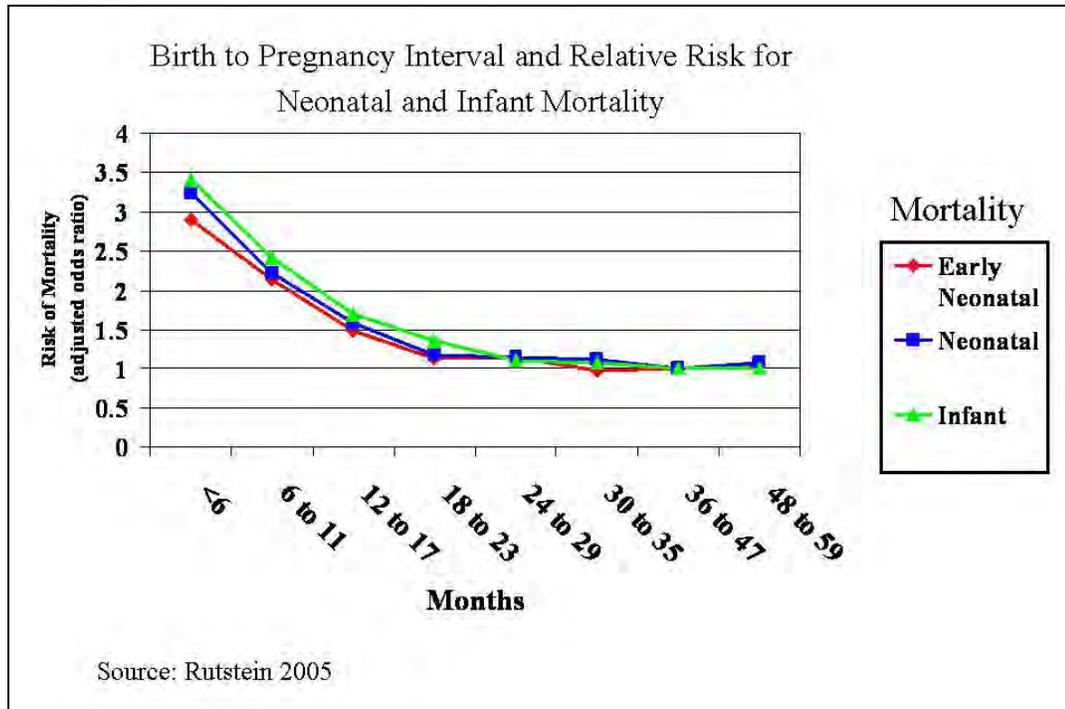
## Research Findings on the Importance of Timing and Spacing of Pregnancy

Research and program experience worldwide indicate that the use of family planning to better time and space pregnancies provides clear health and social benefits to women and their children. The following graphs (Figures 1, 2 and 3) depict some of the major findings of HTSP research.

Although effective pregnancy timing and spacing are positive outcomes related to the use of FP/RH services, few countries have established policies and guidelines that promote postpartum or postabortion pregnancy spacing for the health of mothers and children, despite evidence that suggests much of the unmet need for FP is related to women's desire to space their pregnancies.

Additionally the research clearly shows that young women who become pregnant before the age of 18 face a number of negative health and social outcomes, as do their children<sup>8</sup>.

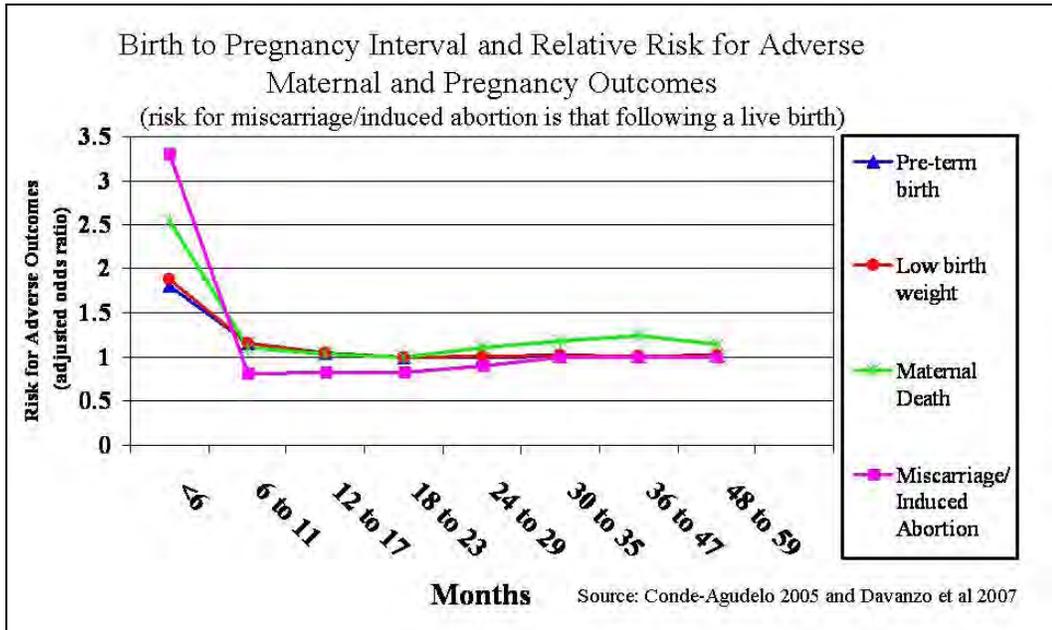
**Figure 1: Improved pregnancy spacing is associated with reduced risk of neonatal and infant deaths.**



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

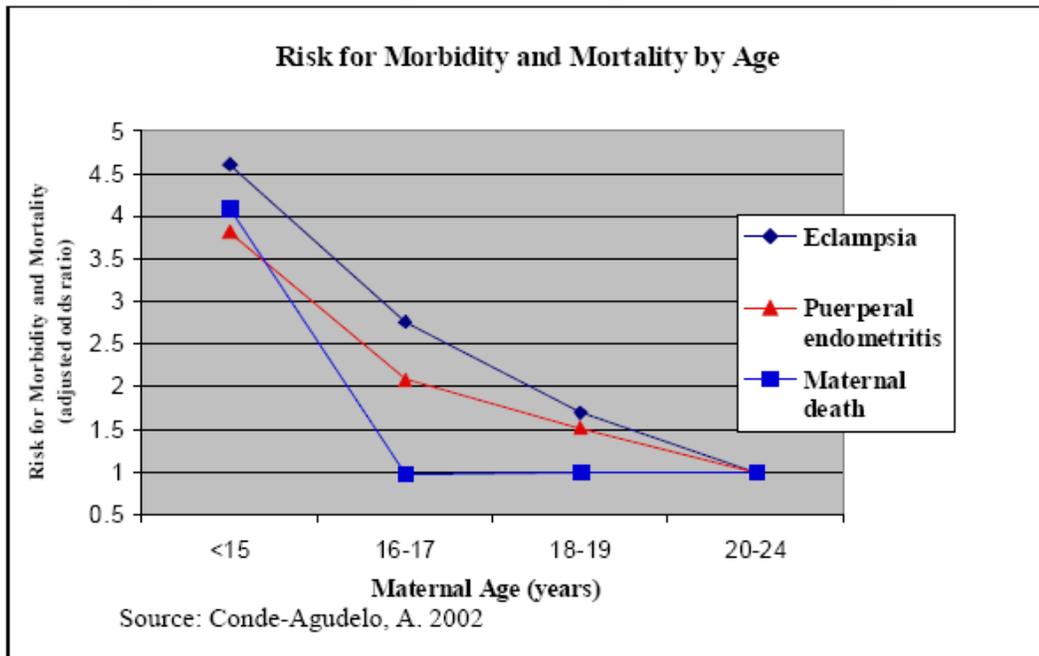
<sup>8</sup> UNFPA (2004) State of the World Population, 2004, <http://www.unfpa.org/swp/2004/english/ch1/index.htm>.

**Figure 2: Improved pregnancy spacing is associated with reduced perinatal and maternal risks.**



A 24-month, birth-to-pregnancy interval is associated with reduced risks of multiple adverse health outcomes for mothers, newborns, and infants. The risk of adverse outcomes is highest with a pregnancy interval of less than six months.

**Figure 3: Young Women Under the Age of 20 Are at Higher Risk for Morbidity and Mortality\***



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

This graph shows that women under the age of 20 are at higher risk for maternal morbidities (eclampsia and puerperal endometritis). The risks of maternal morbidity and mortality are highest when the woman is less than 15 years of age.

## ACHIEVING HTSP OUTCOMES

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

1. Healthy pregnancy spacing of at least 24 months after a live birth.
2. Healthy pregnancy spacing of at least six months after a spontaneous or induced abortion.
3. Healthy timing of the first pregnancy no earlier than age 18 in adolescents.

To help women and couples effectively practice HTSP, health care providers should incorporate the following sets of messages into their information, education and counseling of clients. Providers should always keep in mind that these messages must be delivered within the context of informed contraceptive choice, discussion of fertility intentions and desired family size. In this training, we are focusing primarily on the first message about spacing after a live birth. However, the other messages will also be relevant in many situations.

### The HTSP Messages:

<b>For couples who desire a next pregnancy after a live birth</b>	<b>For couples who decide to have a child after a miscarriage or abortion</b>	<b>For adolescents</b>
For the health of the mother and the baby, wait at least 24 months, but not more than 5 years <sup>9</sup> , before trying to become pregnant again.	For the health of the mother and the baby, wait at least six months before trying to become pregnant again.	For your health and your baby's health, wait until you are at least 18 years of age, before trying to become pregnant.
Consider using a family planning method of your choice during that time.	Consider using a family planning method of your choice during that time.	If you are sexually active, consider using a family planning method of your choice and avoid pregnancy until at least 18 years of age.

### How Does Healthy Timing and Spacing of Pregnancy Contribute to Efforts to Promote the Use of FP?

Family planning programs have made great progress in helping women avoid unintended pregnancies. It significantly contributes to efforts to ensure safe motherhood and child survival by helping women and couples achieve healthy fertility and healthy pregnancy outcomes that in turn reduce maternal and infant illness and death.

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<sup>9</sup> While the WHO 2005 Technical Consultation on birth spacing did not make a recommendation on intervals considered "too long", some technical experts felt it was important to note that for birth-to-pregnancy intervals of five years or more, there is evidence of increased risk of adverse maternal outcomes, namely pre-eclampsia, and adverse perinatal outcomes, namely pre-term birth, low birth weight and small infant size for gestational age.

HTSP emphasizes the health benefits of family planning as a means of preventing unintended pregnancies and for promoting healthy maternal and child health outcomes. Information on the benefits of HTSP may contribute to efforts to help women and families make more informed decisions and increase the overall community's support for the use of FP to space and in some cases limit childbearing.

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

#### *HTSP and HIV positive women*

HTSP is also a good option to discuss with HIV positive women. Many HIV positive women would like to space, delay or limit pregnancy, but do not have quality information or a comfortable environment in which to discuss family planning options. Discussing family planning options with postpartum HIV positive women as part of postpartum care may help them avoid an unintended pregnancy and/or help ensure that their next pregnancy is a healthy one.

Most healthy women can use any method of contraception to practice HTSP. It is the role of the health care provider to inform, educate and counsel women and couples on the best family planning options that are available to them. It is important to reiterate that women and couples must understand that they can freely choose whether or not to use an FP method and that they can freely decide which method they would like to use. Counseling on FP and HTSP should consider and respond to the particular needs of women given her age, marital status, parity, fertility intentions, HIV status and stage of life.

*(Note: This training focuses on spacing of pregnancy, since the target population is postpartum women.)*

### **Components of HTSP Interventions**

There are many opportunities to include information on healthy timing and spacing of pregnancy and a number of health interventions naturally lend themselves to the inclusion of HTSP information. Such programs and services include maternal-neonatal-child health, child survival, post abortion care, HIV/AIDS, prevention of mother to child transmission (PMTCT) of HIV, malaria programs, youth friendly services, cervical cancer screening, and workplace health programs. (This is only a partial list; there are likely to be other services in the community where HTSP can be included.)

To successfully ensure that HTSP information, education, counseling and are made widely available to women and communities, HTSP must be implemented as a comprehensive intervention in multiple venues and settings. The first step is to implement:

- **Training of facility-based service providers and community health workers** that addresses the importance of FP in promoting reproductive health, and maternal, newborn and child health through improved use of HTSP and helps providers develop skills to educate and counsel their clients. Training should include the HTSP messages and the benefits of HTSP for women, their families and the community. For health care providers, training should include information and skills development on how to better assess women's fertility

intentions and desired family size and how to link this information with counseling on FP, as well as adequate information on appropriate contraceptive methods

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

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

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

Program managers and health care providers should also begin to:

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

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

- **Advocate for policies that support HTSP** by bringing evidence on HTSP and its association with reducing maternal and infant morbidity and mortality to the attention of Ministries of Health, policymakers, donors, technical agencies, health care providers, non-governmental organizations, program managers, and community leaders. It is important that policy makers and service providers understand that short pregnancy intervals lead to increased risk of multiple adverse outcomes, and that focused efforts to promote FP for HTSP can improve the health of women and infants, and ultimately, communities.<sup>10</sup>

## **BENEFITS OF HTSP AND RISKS OF NOT PRACTICING HTSP**

Providers, clients, community members and leaders need to understand the clear benefits of HTSP practices. There are many health and social benefits for women, men, children and communities that result from improved use of FP to achieve HTSP. Similarly, there are potential risks when pregnancies are closely spaced. Table 1 presents these benefits and risks.

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<sup>10</sup> To facilitate advocacy efforts, ESD has developed 13 advocacy briefs for countries where FP use is low, maternal, infant and child morbidity and mortality is high, and short birth intervals are common. These are available at [www.esdproj.org](http://www.esdproj.org).

**Table 1: Benefits of HTSP and Risks if HTSP Is Not Practiced**

BENEFITS OF HTSP	RISKS IF HTSP IS NOT PRACTICED
<b>For the Newborn Child</b>	
<ul style="list-style-type: none"> <li>• Newborns are more likely to be born strong and healthy.</li> <li>• Newborns may be breastfed for a longer period of time, which allows them to experience the health and nutritional benefits of breastfeeding.</li> <li>• Mother-baby bonding is enhanced by breastfeeding, which facilitates the child's overall development</li> <li>• Mothers who are not caring for another young child under the age of three may be better able to meet the needs of their newborns.</li> </ul>	<ul style="list-style-type: none"> <li>• Risk of newborn and infant mortality is higher.</li> <li>• There may be a greater chance of a pre-term low-birth-weight baby, or the baby may be born too small for its gestational age.</li> <li>• When breastfeeding stops before six months, the newborn does not experience the health and nutritional benefits of breast milk, and the mother-baby bond may be diminished, which may affect the baby's development.</li> </ul>
<b>For the Mother</b>	
<ul style="list-style-type: none"> <li>• The mother has a reduced risk of complications which are associated with closely spaced pregnancies.</li> <li>• She may have more time to take care of the baby if she does not have to deal with the demands of a new pregnancy.</li> <li>• She may breastfeed longer; longer duration of breastfeeding is linked to a reduced risk of breast and ovarian cancer.</li> <li>• She may be more rested and well-nourished so as to support the next healthy pregnancy.</li> <li>• She may have more time for herself, her children, and her partner, and to participate in educational, economic and social activities</li> <li>• She may have more time to prepare physically, emotionally, and financially for her next pregnancy.</li> </ul>	<ul style="list-style-type: none"> <li>• Women who experience closely spaced pregnancies are:               <ul style="list-style-type: none"> <li>○ at increased risk of miscarriage;</li> <li>○ more likely to induce an abortion; and</li> <li>○ at greater risk of maternal death.</li> </ul> </li> </ul>
<b>For Men</b>	
<ul style="list-style-type: none"> <li>• His partner may find more time to be with him, which may contribute to a better relationship.</li> <li>• Expenses associated with a new pregnancy will not be added to the expenses of the last-born child.</li> <li>• More time between births may allow a man time to plan financially and emotionally before the birth of the next child, if the couple plans to have one.</li> </ul>	<ul style="list-style-type: none"> <li>• The stress from closely spaced pregnancies may prevent couples from having a fulfilling relationship.</li> <li>• If the mother is too tired from a new pregnancy and raising an infant, she may not have the time or energy to spend with her partner.</li> </ul>

BENEFITS OF HTSP	RISKS IF HTSP IS NOT PRACTICED
<ul style="list-style-type: none"> <li>• Men may feel an increased sense of satisfaction from:               <ul style="list-style-type: none"> <li>○ Safeguarding the health and well-being of his partner and children; and</li> <li>○ Supporting his partner in making healthy decisions regarding FP and HTSP.</li> </ul> </li> </ul>	
<b>For the Family</b>	
<ul style="list-style-type: none"> <li>• Families can devote more resources to providing their children with food, clothing, housing, and education.</li> </ul>	<ul style="list-style-type: none"> <li>• A new pregnancy requires money for antenatal care, better nourishment for the mother, savings for the delivery costs and costs associated with the needs of a new baby.</li> <li>• Illness or a need for emergency care is more likely if the woman has closely spaced pregnancies</li> <li>• Unanticipated expenses may lead to difficult financial circumstances or poverty.</li> </ul>
<b>For the Community</b>	
<ul style="list-style-type: none"> <li>• HTSP is associated with reduced risk of death and illnesses among mothers, newborns, infants, and children, which can contribute to reductions in poverty and improvements in the quality of life for the community.</li> <li>• It may relieve the economic, social and environmental pressures from rapidly growing populations.</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of HTSP may result in a poorer quality of life for community residents, including increased medical expenses.</li> <li>• Economic growth may be slower, making it more difficult to achieve improvements in education, environmental quality, and health.</li> </ul>

## **Opportunities to Integrate HTSP Education and Counseling into Existing Services for Postpartum Women**

There are many opportunities to introduce or reinforce HTSP messages in the health education and counseling services that are provided to postpartum women. HTSP can also be integrated into other programs and services such as antenatal care; child survival services; HIV/AIDS prevention, care and treatment; malaria prevention and treatment; cervical cancer screening; and services that are specially targeted to youth and/or men among many others. There are also a number of community-based activities and settings where it is appropriate to discuss HTSP. These opportunities are highlighted below.

### **Postpartum Care**

The postpartum return visit or newborn checkup is a good time to provide HTSP information and counseling, because the mother is likely to be eager to hear what she can do to ensure the health of her newborn, as well as herself. The health worker can emphasize the benefits of HTSP by advising the client that:

- For the healthiest outcomes for both mother and baby, a woman should wait at least two years after the birth of her child before trying to become pregnant again.
- HTSP will give her more time and energy to care for the newborn.
- HTSP will help her exclusively breastfeed for six months and continue to breastfeed for two years as recommended by WHO and UNICEF. If she were to become pregnant, she would have to wean the baby.
- Exclusive breastfeeding also provides contraceptive protection (also known as the Lactational Amenorrhea Method or LAM) for the first six months postpartum and is an important aspect of HTSP for postpartum mothers (LAM is discussed further in the next session).
- She will be stronger, healthier, and better nourished, which will prepare her for another healthy pregnancy, if she and her partner decide to have another baby.
- She will not have to deal with the demands of a new pregnancy while still caring for a newborn.
- She may have more time to spend with her family.
- If she is interested in spacing her next birth, or has reached her desired family size, there are a number of family planning methods that she can use. Women who have reached their desired family size may be particularly interested in long-acting and permanent methods (LAPM). (LAPMs are discussed further in the next session)

### **Child Health Services**

Postpartum women are likely to use child health services. Routine child health visits, immunizations, growth and development monitoring, and/or treatment of illness present a natural opportunity to discuss pregnancy spacing, limiting and FP with mothers, based on their reproductive goals and desired family size. During these visits, the health worker can discuss how using FP for HTSP will benefit children's health. The health worker should:

- Tell the mother that she should wait at least two years after the birth of her last child before trying to become pregnant again, should she wish to have another child.
- Encourage her to adopt a method of FP (if she has not already done so) to space her next pregnancy. If she has reached her desired family size and does not want any more children, she may wish to consider using a long-acting or permanent method.

- Reinforce the health benefits for the baby by pointing out that using FP for HTSP will give the mother more time to breastfeed the baby, which will support the child's healthy development.
- Explain that there are a variety of family planning methods that can help the mother to space her next pregnancy or prevent an unwanted pregnancy.

***Immunizations: An Important Point of Contact for HTSP***

The IMMUNIZATION Basics project suggests that immunization contacts are an important place where HTSP and FP information, services and referrals can easily be provided, especially where immunization rates are high, based on a 1994 study conducted in Togo. This study found that pairing Expanded Program in Immunization (EPI) services with simple messages for the mother on the importance of spacing her next pregnancy through the use of FP resulted in a significant increase in awareness of FP services and the use of those services by EPI clients. Such personalized messages also seemed to be more effective than group health education talks.

**A Special Concern: Malaria, Pregnancy and HTSP**

Malaria is a leading cause of pregnancy complications, including anemia, miscarriage, still birth and premature birth, particularly in sub-Saharan Africa, and poses a special threat to the health of pregnant women and newborns. Increasingly, MCH, antenatal, postpartum and child survival programs are focusing on improving efforts to prevent and treat malaria among pregnant women and children through the use of intermittent preventive treatment (IPT) and insecticide treated bed nets (ITN). Healthy timing and spacing of pregnancy (HTSP) can be implemented as essential preventive child survival interventions to complement curative care and other child health interventions.

**Other Important Services**

HTSP and family planning information and services are relevant to many other services provided in the clinic or in the community, including:

- **Antenatal Care**

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

- She should wait at least two years after the birth of her last child before trying to become pregnant again.
- Her child will benefit from her attention and care if she does not become pregnant again too quickly.
- If she becomes pregnant before this child is at least two, it may affect the child's health and development, especially if she has to wean the child.
- She will be able to provide the best care for her children if their births are adequately spaced.
- If she is interested in spacing her next birth, or has reached her desired family size there are a number of family planning methods that she can use, including long-acting and permanent methods.

- **Family Planning Services**

Women seek FP services to learn how to delay pregnancy, prevent an unplanned pregnancy or limit their childbearing, and FP visits are an important time to discuss how using FP will help them achieve the benefits of HTSP. Family planning counseling is strengthened by considering the desired family size of women and couples, fertility intentions, interest in healthy fertility and childbearing, and the health and social benefits of spacing. In addition to counseling on the use of a method, providers should discuss how to use a method to practice HTSP. (FP counseling for HTSP is addressed in greater detail in the next Session.)

- **Postabortion Care**

Women who have experienced a miscarriage or an induced abortion should be advised that fertility may return anywhere from 10 days to two weeks. All women receiving postabortion care need to be given counseling and information to make sure they understand that they could become pregnant again before the return of their menses. During postabortion counseling, the provider can discuss the advantages of HTSP by informing the client that she should wait at least six months after a spontaneous or induced abortion before trying to become pregnant again (should she wish to do so). To ensure that she does not become pregnant again too quickly, she should use a contraceptive method. All contraceptive methods are appropriate for use after an induced or spontaneous abortion.

Women who do not wait six months and become pregnant again may experience adverse outcomes and complications such as anemia, premature rupture of membranes, pre-term delivery, low-birth weight and small for gestational age. Women who do not want to become pregnant again because they have reached their desired family size should also be encouraged to use a contraceptive method to prevent an unwanted pregnancy. These women may be particularly interested in long-acting and permanent methods (LAPM).

- **Youth Services**

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

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

*Youth Services for Married Adolescents*

Many youth friendly services are targeted to unmarried adolescents; in fact, married adolescents are at greater risk of early pregnancy, and subsequent closely spaced pregnancies.

Discussing contraceptive use to delay pregnancy with their husbands is difficult, they are often pressured to become pregnant immediately after marriage, and are often overlooked by existing youth or MCH programs. As more programs are established to meet the needs of adolescents, it is important to consider and address both married as well as unmarried young women through improved access to HTSP information, education and FP services so that young women have greater opportunities to delay their first pregnancy till at least age 18 and safely space subsequent pregnancies.

- **HIV/AIDS Services**

Women may attend HIV/AIDS prevention, care and treatment services:

- if they are at risk and wish to prevent the transmission of HIV;
- to determine if they are infected with HIV;
- to prevent transmission to the baby during or after pregnancy;
- to provide care for people living with HIV/AIDS; and
- to address the impact of HIV/AIDS on themselves, their families, and communities.

HTSP counseling and FP can easily be integrated into voluntary counseling and testing (VCT) and prevention of mother to child transmission (PMTCT) programs and services. Recent research shows that as more women are enrolled in ART programs, a return to fertility can become a significant concern. While some women may want to prevent pregnancy, others may wish to ensure a healthy pregnancy.

As with any client, it is important to assess the fertility intentions and desired family size of a woman with HIV. PMTCT programs can dramatically decrease the risk of a mother passing on HIV to her baby during pregnancy and delivery. It is important to advise HIV positive women that pregnancy places a heavy burden on her body and overall health, so she could be careful to limit her pregnancies, and space them adequately so she has time to recover between pregnancies. It is extremely important for her health and the health of the baby that she attend antenatal care. Most FP methods can safely be used by HIV positive women for spacing or pregnancy prevention.

*A Note About Breastfeeding and HIV*

Women with HIV who give birth should be counseled to use replacement feeding if it is acceptable, feasible, affordable, sustainable and safe. If any one of these criteria cannot be met, HIV positive women should breastfeed exclusively during the first six months. This reduces the risk of HIV transmission to her child by half as compared to mixed feeding, prevents infant death due to other illnesses, and provides her with protection against pregnancy through LAM. After six months she should switch completely to replacement foods for her child and choose another contraceptive method to delay, space or limit pregnancy.

- **Cervical Cancer Screening Programs**

Cervical cancer affects nearly 500,000 women worldwide each year, with more than 270,000 women dying from cervical cancer. Increasingly, cervical cancer screening programs are being established in hospitals and clinics, using low cost and effective technologies for detection and treatment. The Alliance for Cervical Cancer Prevention recommends that women aged 30 - 40 be screened for cervical cancer so that cancer can be detected early and treated. This is an opportune time to reach this key group of women with HTSP and FP

information and services, especially those women who have reached their desired family size and are not interested in having more children.

- **Men's Health Services**

Men's health services promote health and wellness in men and boys. Including information about HTSP can help men learn how HTSP will benefit men and their families how they can practice HTSP by using condoms or helping their partner to adopt an FP method. There are an increasing number of male-focused programs that are designed to help men acquire information and develop new skills to address their reproductive health, as well as the health of their wives and partners. HTSP is a relevant topic to be included in such programs.

- **Community Outreach**

Many health programs have a community outreach component which is implemented by community health workers (CHWs). CHWs bring health care to community members and provide health education on a number of topics, including FP and MCH. As part of their outreach activities, CHWs can educate men, women and youth about the benefits of using FP for HTSP. CHWs may be more likely to interact with family decision-makers such as husbands or mothers-in-law. The CHWs can explain how FP and HTSP can contribute to ensuring and even improving the health of mothers, children and families.

## Session 4: Postpartum Family Planning

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### Session Objectives

At the end of this session, participants will be able to;

- describe appropriate FP methods for postpartum women;
- recommend appropriate FP for postpartum women, based on her breastfeeding status; and
- understand and apply concepts of Lactational Amenorrhea Method (LAM).



### Time

90 minutes



### Materials

- Flip chart and markers
- Power point presentation/transparencies
- Handouts
  - Handout #8 Contraceptives for Postpartum Women
  - Handout #9 When to Initiate Contraceptive Use for Postpartum Women
  - Handout#10 Long Acting and Permanent Methods
  - Handout #11 Lactational Amenorrhea Method (LAM)



### Advance Preparation

- On one piece of flip chart paper, write BREASTFEEDING WOMEN. Write NON-BREASTFEEDING WOMEN on a second piece of paper.

Write the name of the following contraceptive methods on an index card (one method per card): LAM, Condoms, Combined Oral Contraceptives, Progestin Only Pills, IUDs, Injectables, Tubal Ligation, Vasectomy, Implants. (Include other methods as they are available in your community)

Make sure you have at least one card per participant, or at least two sets of cards for each method. You will probably need to write the name of a contraceptive on more than one card.

- Post the Postpartum Case Studies 1, 2 and 3 and the LAM Case Studies 1, 2 and 3 on flip chart paper:

Postpartum Case Study #1	Postpartum Case Study #2	Postpartum Case Study #3
A 35 year old woman has just delivered her fourth child. She has come today with her husband	A 22-year-old woman had her baby a month ago. She brings the baby for a well-baby visit.	A sixteen year old woman is seen at the health center with complications from a miscarriage. She has an eight month old daughter.

<b>LAM Case Study #1</b>	<b>LAM Case Study #2</b>	<b>LAM Case Study #3</b>
A mother with a three-month-old baby who breastfeeds and has already had her menstrual period.	A mother with a two-week-old baby; fully breastfeeds, has vaginal bleeding.	A mother with a two-month-old baby; has not had a menstrual period; she breastfeeds and gives the baby a bottle of sugar-water a few times a day.

- Make copies of Handouts

### **Training Activities**

1. *Presentation and Discussion on Postpartum Contraception, including LAM and LAPM. (30 minutes)*

Distribute Handouts:

- Handout #8 Contraceptives for Postpartum Women
- Handout #9 When to Initiate Contraceptive Use for Postpartum Women
- Handout #10 Long Acting and Permanent Methods
- Handout #11 Lactational Amenorrhea Method (LAM)

2. *Large Group Exercise and Discussion (15 minutes)*

- Distribute the index cards with the names of contraceptive methods written on them. Each participant should have at least one card.
- Ask participants to decide if the card that they are holding is a method that is appropriate for women in the immediate postpartum period depending on whether or not they are breastfeeding.
- Have participants paste or tape their card with the name of the contraceptive method under the appropriate sign: "BREASTFEEDING" or "NON-BREASTFEEDING."
- Collect cards and redistribute them. Repeat the exercise, this time asking participants to think about women who are six weeks postpartum.
- Repeat one more time for women who are six months postpartum.

Now, remind the participants of the three stages of the postpartum period and ensure that they have correct understanding of which methods can be used at the different stages. Encourage participants to refer to their handouts to identify the different contraceptive methods that can be used.

Ask participants:

- What actually happens in the clinic or health facility where you work?
- Should you change the way you present postpartum family planning to your clients?
- What kind of change and how might you facilitate this change?
- Did participants learn anything new from this activity?

3. *Small group work (40 minutes)*

- Divide participants into three groups.
- Remind participants of the role plays they did earlier in the workshop. Tell them that participants will use those same role plays, but approach them as a case study. The purpose of the case study is to consider the types of FP method(s) that women should use to space or prevent her next pregnancy.
- Assign one case study to each group. Ask each group to identify one person to record the responses and another person to share the groups' findings and recommendations to the larger group.
- Instruct participants to refer to the HTSP messages and the handouts on contraceptive methods when discussing the case studies.

Have each group answer the following questions about the case study:

- Is this a good opportunity to address HTSP and FP?
- What are the client's information needs?
- What kind of concerns might the client have?
- What types of services should be provided?

**LAM Case Studies**

Next assign one LAM Case study to each group.

Have participants answer the following questions:

- Does this woman meet the three criteria for LAM use?
- How should you counsel this woman on LAM?
- Can she successfully use LAM?
- What other information or advice would you give her?

Ask participants to report back their main findings to the larger group.

4. *Summarize and Wrap-up (5 minutes)*

**Key Messages**



- √ Postpartum infertility in non-breastfeeding women may last four weeks. In breastfeeding women, the period of infertility is longer, as breastfeeding provides some protection against pregnancy for up to six months.
- √ Contraceptive protection from for women who are not menstruating AND who exclusively breastfeed an infant less than six months old is also known as the Lactational Amenorrhea Method (LAM). The effectiveness of LAM is determined by the amount of time the infant spends suckling at the breast.
- √ It is difficult to predict the return to fertility as women may become fertile (i.e., ovulate and thus be able to become pregnant) before she has any signs of menstruation. If one of the LAM criteria is not met, the women should use an FP method of her choice.
- √ By initiating postpartum contraception and continuing to provide contraceptive services providers can help women prevent an unintended pregnancy or space her next pregnancy by at least 24 months after childbirth, because a closely spaced pregnancy may be harmful to the health of the mother or the baby.

- √ Most postpartum women can safely use a number of contraceptive methods. The type of method a postpartum woman chooses depends in part on whether or not she is breastfeeding.

## POSTPARTUM FAMILY PLANNING

ACCESS-FP<sup>11</sup> defines the extended postpartum period as the first year after delivery, since this is when it is most important time to ensure women accept family planning services. This period is of particular importance, because it is a time when women are especially vulnerable to unintended pregnancy. It is beneficial to the health of both mother and child to use FP to prevent an unintended or unwanted pregnancy, or to space the next birth by 24 months.

A baby's suckling of the breast stimulates the production of the hormone prolactin, which facilitates milk production and inhibits ovulation. Immediately following delivery, every woman experiences a period of infertility. Immediate postpartum infertility is not due to the levels of prolactin but because of the high levels of progesterone and estrogen that are produced by the placenta. With the expulsion of the placenta, the level of these hormones begins to decrease. However, the decrease in these hormones is balanced by an increase in the production of prolactin in women who breastfeed.

98 percent of women who exclusively breastfeed for the first six months postpartum AND who are not menstruating will not become pregnant. In contrast, a woman who does not exclusively breastfeed or who does not breastfeed at all can become pregnant as soon as four to six weeks after childbirth. The return to fertility, however, is unpredictable. Ovulation may occur and a woman can become fertile before she has any signs or symptoms of menstruation.

### ***Return to Fertility: A Distinction Between Postabortion and Postpartum Women***

The return to fertility differs significantly for postabortion and postpartum women. Following an abortion or miscarriage, a woman's fertility returns within 10 – 14 days. Women who have experienced an abortion or miscarriage should begin the use of contraceptive method within 48 hours following the incident to prevent an unintended or unsafe pregnancy. Research shows that women who become pregnant again within six months of a miscarriage or abortion are much more likely to experience pregnancy related complications.

For postpartum women, it is a bit more complicated. Non-breastfeeding women can ovulate and become pregnant as soon as four to six weeks after delivery. Fertility is less predictable in breastfeeding women. If they are not exclusively breastfeeding, and start supplemental feeding of their babies, they are at risk of pregnancy, even if their menses has not yet returned. To avoid pregnancy, they should see a health care provider who can help them choose an FP method that is appropriate for them.

<sup>11</sup> The ACCESS-FP Program is a 5-year, USAID-sponsored global program with the goal of responding to the significant unmet needs for family planning among postpartum women. As an Associate Award through the ACCESS Program, ACCESS-FP is implemented by Jhpiego in partnership with Save the Children, Constella Futures, the Academy for Educational Development, the American College of Nurse-Midwives and IMA World Health.

## Contraception for Postpartum Women

A woman who chooses to begin a contraceptive method after giving birth must consider several factors, including her breastfeeding status and the type of method she wants to use. The following methods can be used by most postpartum women. Education and counseling should be provided by a health care provider so that she can select and use the method that is best for her.

**Table 2: Family Planning Methods for Postpartum Women**

FP METHOD	BENEFITS	LIMITATIONS
<p><b><i>Lactational Amenorrhea Method (LAM)</i></b> LAM provides protection from pregnancy for up to six months.</p> <p>LAM is only effective if the woman is only breastfeeding, her menstruation has not returned and the baby is less than six months old. Once one of these criteria changes, she should adopt another method.</p> <p>Two out of 100 women using LAM alone in the first six months after childbirth will become pregnant</p>	<ul style="list-style-type: none"> <li>- No side effects or health risks.</li> <li>- Encourages breastfeeding which provides health benefits to the baby.</li> <li>- No cost</li> <li>- Can be used by all women.</li> </ul>	<ul style="list-style-type: none"> <li>- Must be only breastfeeding, which may be difficult for some women to practice.</li> <li>- Is not effective once a woman is not only breastfeeding (mixed feeding), her menstruation returns or the baby is more than six months old.</li> <li>- Does not protect against STIs and HIV.</li> </ul>
<p><b><i>Condoms</i></b> Male condoms are readily available and inexpensive</p> <p>Female condoms are becoming increasingly available.</p> <p>Both types of condoms provide protection against pregnancy and STIs.</p> <p>15 out of 100 women using male condoms alone will become pregnant, while 21 of 100 women using female condoms alone will become pregnant.</p>	<p>For male condoms:</p> <ul style="list-style-type: none"> <li>- Effective immediately</li> <li>- Do not interfere with breastfeeding</li> <li>- Can be used as a backup for other methods</li> <li>- No health risks or side effects</li> <li>- Do not require clinical assessment or prescription</li> </ul> <p>For female condoms:</p> <ul style="list-style-type: none"> <li>- Female controlled method</li> <li>- Does not interfere with intercourse, as it may be inserted up to eight hours before sex.</li> </ul>	<p>For male condoms:</p> <ul style="list-style-type: none"> <li>- Effectiveness depends on the user. Condoms are most effective when they are used consistently and correctly</li> <li>- Some do not like how condoms feel</li> <li>- Women may find it difficult to discuss condom use with their partners</li> <li>- Persistent rumors and misinformation about condoms.</li> <li>- A new condom must be used with each act of intercourse</li> </ul> <p>For female condoms:</p> <ul style="list-style-type: none"> <li>- More limited access and can be expensive</li> <li>- Effectiveness depends on willingness to follow instructions</li> <li>- Supply and resupply may not be readily available</li> <li>- A new condom must be used with each act of intercourse</li> </ul>

FP METHOD	BENEFITS	LIMITATIONS
<p><b>Progestin Only Pills (POPs)</b> POPs (also known as the “mini-pill”) contain a low dose of progestin, which is similar to the hormone progesterone. POPs are appropriate for breastfeeding women, because they do not interfere with breast milk production, and breastfeeding enhances the effectiveness of POPs. Among breastfeeding women, only one (1) woman out of 100 will become pregnant.</p> <p>Among non-breastfeeding women, three to ten (3 to 10) women out of 100 will become pregnant.</p>	<ul style="list-style-type: none"> <li>- Safe for nearly all women, especially breastfeeding women</li> <li>- Highly effective, reversible, easy to use.</li> <li>- Effective within first cycle.</li> <li>- Can be provided by trained non-medical staff.</li> </ul>	<ul style="list-style-type: none"> <li>- Must be taken every day.</li> <li>- Requires regular/dependable supply.</li> <li>- May cause side effects in some women</li> <li>- Do not protect against STIs and HIV.</li> </ul>
<p><b>Combined Oral Contraceptives (COCs)</b> COCs contain low doses of progestin and estrogen. They are safe for nearly all women to use.</p> <p>Postpartum women who are breastfeeding should not use COCs for the first six months, because the hormones interfere with breast milk production.</p> <p>Postpartum women who are not breastfeeding can initiate use of COCs three weeks after childbirth.</p> <p>Postpartum women who are breastfeeding can start COCs when her menses return, or she is no longer fully breastfeeding or at six months postpartum, whichever comes first.</p> <p>Approximately eight (8) out of 100 women will become pregnant using COCs.</p>	<ul style="list-style-type: none"> <li>- Safe for nearly all women, except breastfeeding women in the first six months postpartum.</li> <li>- Highly effective, reversible, easy to use.</li> <li>- Can be provided by trained non-medical staff</li> </ul>	<ul style="list-style-type: none"> <li>- Must be taken every day.</li> <li>- Requires regular/dependable supply.</li> <li>- May cause side effects in some women</li> <li>- Side effects such as changes in bleeding patterns must be addressed to ensure the client continues with COCs.</li> <li>- Do not protect against STIs and HIV</li> <li>- Breastfeeding women should not use COCs in the first six months postpartum, as COCs decrease milk production.</li> </ul>
<p><b>Progestin-only Injectables</b> Progestin-only injectables are appropriate for most breastfeeding women. This is a very effective method and it does not interfere with breast milk production. About three (3) women out of 100 will become pregnant using injectables.</p>	<ul style="list-style-type: none"> <li>- Very effective, reversible and few side effects, such as changes in menstrual bleeding (e.g., spotting initially and then no menses). Some also experience weight gain</li> <li>- No effect on breast milk production</li> <li>- Does not interfere with sexual intercourse.</li> <li>- No need for daily pill-taking.</li> <li>- Effective within 24 hours.</li> </ul>	<ul style="list-style-type: none"> <li>- May cause side effects in some women.</li> <li>- Most women experience a delayed return to fertility (for half of the users, it takes 6 to 9 months after discontinuation to get pregnant).</li> <li>- Requires regular injections. One type is administered every two months, while the other is administered every three months.</li> <li>- Do not protect against STIs and HIV.</li> </ul>

FP METHOD	BENEFITS	LIMITATIONS
<p><b><i>Intrauterine Contraceptive Device (IUCD)</i></b> The copper-bearing IUCD is appropriate for breastfeeding women. The IUCD can be inserted within the first 48 hours postpartum, or between four weeks and six months postpartum, as long as the woman has no contra-indications and it is reasonably certain that she is not pregnant.</p> <p>IUCDs are a highly effective, long-term method. Less than one (1) woman out of 100 women using IUCDs will become pregnant.</p>	<ul style="list-style-type: none"> <li>- Immediately effective upon insertion.</li> <li>- Does not interfere with sexual intercourse.</li> <li>- Immediately reversible with no delay in return to fertility.</li> <li>- Does not interfere with breastfeeding.</li> <li>- No interactions with any medicines.</li> <li>- No hormonal side effects</li> <li>- No need for follow up unless there are problems.</li> <li>- No need to purchase any supplies.</li> </ul>	<ul style="list-style-type: none"> <li>- Possibility of longer and heavier menstrual periods; bleeding or spotting between periods; more cramps or pain during periods.</li> <li>- Does not protect against STIs and HIV.</li> <li>- Requires a trained health care provider to insert and remove the IUCD.</li> </ul>
<p><b><i>Implants</i></b> Implants that contain progestin can be used by breastfeeding women. Implants are small plastic rods that are inserted under the skin of a woman's upper arm.</p> <p>If the woman is breastfeeding, implants can be used at around six weeks postpartum</p> <p>Implants are a very effective, long-term method that last for 3 – 5 years. Less than one (1) woman out of 100 using implants will become pregnant.</p>	<ul style="list-style-type: none"> <li>- Very effective contraceptive.</li> <li>- Immediate return to fertility once implants are removed</li> <li>- Does not interfere with breastfeeding</li> <li>- No need for return visits or purchase of supplies</li> </ul>	<ul style="list-style-type: none"> <li>- Possibility of changes in bleeding patterns. Some women may experience other side effects.</li> <li>- Do not protect against STIs and HIV</li> <li>- Requires trained provider to insert and remove implants</li> </ul>
<p><b><i>Voluntary Sterilization</i></b> Tubal ligation (for women) and vasectomy (for men) are very effective contraceptive methods. These methods are permanent and should not be considered reversible. Written consent is required from the client.</p> <p>Less than one (1) woman out of 100 will become pregnant after either male or female sterilization.</p>	<p>For women:</p> <ul style="list-style-type: none"> <li>- Simple surgery using local anesthesia.</li> <li>- Nothing to remember, no supplies, no repeat visits.</li> <li>- No effect on breast milk production</li> <li>- No known long-term side effects or health risks.</li> <li>- Can be performed any time when it is reasonably sure that the woman is not pregnant.</li> </ul> <p>For men:</p> <ul style="list-style-type: none"> <li>- Simple surgery performed using local anesthesia.</li> <li>- Nothing to remember, except condoms for the first 3 months.</li> <li>- No known long-term side effects.</li> <li>- Easier than tubal ligation.</li> <li>- No change in sexual function.</li> </ul>	<ul style="list-style-type: none"> <li>- Uncommon complications of surgery include: <ul style="list-style-type: none"> <li>• Infection</li> <li>• Bleeding at the incision</li> <li>• Injury</li> </ul> </li> <li>- Requires a trained provider.</li> <li>- Must be considered permanent.</li> <li>- Does not protect against STIs and HIV.</li> <li>- Short-term discomfort/pain following procedure.</li> <li>- Must be considered permanent.</li> <li>- Delayed effectiveness (requires at least 3 months or more than 20 ejaculations for procedure to be effective).</li> <li>- Requires a trained provider.</li> <li>- Does not protect against STIs and HIV.</li> </ul>

*Of special note: Women who have HIV can start and continue to use most contraceptives safely, with some limitations, including LAM. In general, contraceptives and anti-retroviral medications do not interfere with each other.*

## **Lactational Amenorrhea Method (LAM)**

Because many women choose to breastfeed after giving birth, Lactational Amenorrhea Method (LAM) is a contraceptive option which also ensures optimal nutrition for the baby.

LAM is a short-term FP method because breastfeeding naturally suppresses a woman's fertility for up to six months. LAM is effectively practiced if the mother **only breastfeeds**. Only breastfeeding is the healthiest option for newborn nutrition for the first six months of life, and women who are only breastfeeding are protected against pregnancy for up to six months postpartum.

To effectively practice LAM to prevent pregnancy, the following three conditions **MUST** be met:

1. breastfeeding only;
2. no menses since delivery (with the definition of menses as “any bleeding after two months”); and
3. the baby is less than six months old.

During the first six months postpartum, a woman who only breastfeeds day and night (on demand) is unlikely to ovulate before her menses resume. Once a woman starts to menstruate, ovulation has resumed and a woman can become pregnant. Menstruation is considered to have returned when a woman experiences any bleeding after two months postpartum.

It is important to counsel a woman, however, that she will ovulate and be fertile before she has any signs and symptoms of menstruation. She **should not** wait until the return of her menstruation as the sign that she is again fertile and needs to begin using a method of contraception. If she does not want to become pregnant again too soon or wants to limit pregnancy altogether, she should choose an FP method **before** she has completed the period of exclusive breastfeeding and **before** the return of her menses.

Counseling should include information on HTSP. Any follow up visits should continue to support and discuss her transition to another method, and the FP options that are available to her.

### *HIV positive Women and LAM*

LAM can be used by HIV positive women for the first six months postpartum as long as all three criteria for LAM are met. By six months postpartum and before the baby has been weaned, the woman should start using another family planning method for pregnancy prevention. She should continue use condoms to prevent STIs and reinfection with HIV.

## **Fertility Awareness Based Methods**

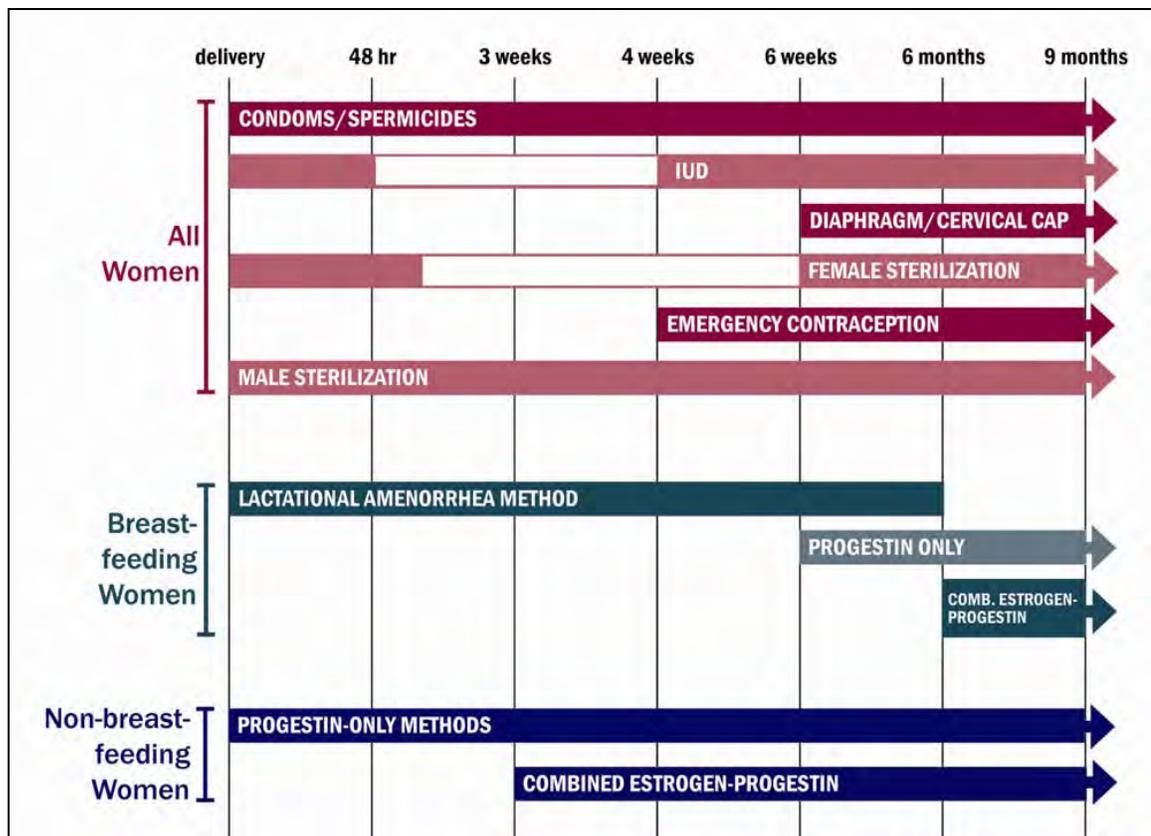
Fertility Awareness Based (FAB) methods identify the fertile and infertile days of the menstrual cycle. Couples using FAB methods learn to tell when sexual intercourse is most likely to result in pregnancy and can time intercourse, or use a back up method such as a condom, depending on whether or not they wish to become pregnant. Successful use of these methods depends on the ability of the couple to use it correctly and to avoid unprotected sex when the woman is fertile.

The Standard Days Method (SDM) is an FAB method that works by identifying the days when a woman is most likely to become pregnant. CycleBeads are given to women to help them keep track of their menstrual cycles. CycleBeads are color-coded beads to show infertile and fertile days. This method requires the cooperation of both partners. It is most appropriate for women with regular cycles that are no less than 26 and no more than 32 days long.

### When Postpartum Women Can Initiate Contraceptive Use

Figure 4 (below) shows the methods that are most appropriate for postpartum women in the immediate and extended postpartum periods, depending on whether or not women are breastfeeding

**Figure 4: When postpartum women can begin using contraception**<sup>12</sup>



### Postpartum Contraception and Women with HIV

HIV infected people may show no signs of illness but can still infect others. An HIV-positive mother can pass on the disease to her child during pregnancy, labor, delivery and breastfeeding. This is referred to as mother-to-child transmission (MTCT) or vertical transmission. Comprehensive

<sup>12</sup> Adapted by ACCESS-FP from the MAQ Exchange: Contraceptive Technologies Update.

postpartum follow-up and care for women living with HIV/AIDS and their infants should go beyond the traditional six weeks postpartum, since HIV positive women may have more problems healing after delivery and may be more susceptible to infection. They may also be more likely to experience psychological problems, such as depression.

The postpartum period is an excellent time to reach HIV positive women with information and care that is specific to their situation. Health care providers can help HIV positive women and their partners to make informed reproductive health decisions. Important services to provide during postpartum care include information on how to prevent mother to child transmission of HIV, safe infant feeding practices; family planning education, counseling and services (including information on dual protection) for healthy timing and spacing or limiting of pregnancy; psychological and emotional support for women's choices and decisions; and referral for other services.

The following is important to provide to HIV positive women so that they make an informed choice about the use of a family planning method:

### **Condoms**

Condoms provide dual protection against both pregnancy and HIV transmission, and prevent reinfection of the mother with HIV. Reinfection with HIV can increase the risk of a breastfeeding mother to transmit HIV to the baby and can cause additional health problems for the mother. HIV positive women, regardless of the contraceptive method they use should be counseled to use condoms consistently and correctly. This is especially true if her partner is HIV negative, as she can infect her partner if they do not use condoms. Another consideration is when both partners are HIV positive. If condoms are not used consistently and correctly, re-infection with HIV can occur. HIV reinfection can be very problematic for the health of HIV infected people and can increase the risk of transmitting HIV to a baby during breastfeeding.

### **Lactational Amenorrhea Method (LAM)**

LAM can be used by HIV positive women for the first six months postpartum as long as all three criteria for LAM are met. By six months postpartum and before the baby has been weaned, the woman should start using another family planning method for pregnancy prevention. She should continue using condoms to prevent STIs and reinfection with HIV.

### **Other FP Methods**

HIV positive women who are using replacement feeding and wish to space or prevent pregnancy will need to use a contraceptive soon after delivery, since postpartum infertility in non-breastfeeding women may last less than six weeks.

Any method of contraception is appropriate for an HIV positive woman, including the IUD, with the exception of spermicides and diaphragms. Spermicides and diaphragms provide no protection against STIs or HIV, and frequent use of spermicides actually increase the risk of HIV infection by causing irritation of the vagina, which makes it easier for the virus to get into the body.

Most HIV positive women can safely use pills, injectables or permanent methods. HIV positive women who are being treated for tuberculosis with rifampicin should probably not use low-dose combined oral contraceptives as rifampicin may limit their effectiveness. They can, however, safely use injectables.

## Session 5: Postpartum Family Planning Counseling for HTSP

### Session Objectives

By the end of this session, participants will be able to:

- Educate and counsel postpartum women on using FP for HTSP



### Time

90 minutes



### Materials

- Flip chart and markers
- Power point presentation or transparencies
- Handouts
  - Handout 12 GATHER adapted for HTSP
  - Handout 13 What makes FP counseling effective?
  - Handout 14 Family Planning Counseling Strategies for Different Clients
  - Tool # 4 FP for HTSP Counseling Checklist



### Advance Preparation

- Make copies of Handouts
- Post Role Plays #1, #2 and #3 on flip chart paper

Role Play #1	Role Play #2	Role Play #3
A 35 year old woman has just delivered her fourth child. She has come to the clinic today with her husband.	A 22-year-old woman had her baby a month ago. She brings the baby for a well-baby visit.	A sixteen year old woman is seen at the health center with complications from a miscarriage. She has an eight month old daughter

### Training Activities

1. *Presentation and Discussion on Postpartum Family Planning Counseling for HTSP, using GATHER adapted for HTSP (30 minutes)*

Distribute Handout 12 GATHER for HTSP

2. *Group Exercise (10 minutes)*

Ask participants to close their eyes for a few minutes and think of a moment in their life when they had a concern or problem that they were uncomfortable or embarrassed to share with others.

Now have participants open their eyes. Ask participants "How comfortable would you be if I asked you to share that situation with the person next to you?"

Point out that it is difficult for many clients to comfortably discuss private concerns with a counselor. Counselors must build trust and rapport, and encourage dialogue with a client that maintains privacy and confidentiality.

3. *Distribute Tool #4 FP for HTSP Counseling Checklist and review (10 minutes)*

Point out a checklist is a good way to help us remember important points to address with clients when discussing FP and HTSP.

4. *Role Plays. Ask for volunteers to play the following parts in the role plays. (35 minutes)*

- Role play #1 Woman, Health Care Provider, Husband
- Role play #2 Woman, Health Care Provider
- Role play #3 Woman, Health Care Provider

Ask the participants who are playing the "health care provider" to use the "GATHER for HTSP" tool when educating and counseling the "Client."

The participants who are not acting in the role play should observe the role play, using the Counseling Checklist.

The role play should last 5 - 7 minutes.

Have participants perform role play #1.

After the role play, ask the following questions and record participant responses:

- What did you think about the counseling that was provided? What worked? What didn't?
- Did the counselor effectively use "GATHER for HTSP?" Why or why not?
- What are some other ways to have counseled the client?
- Were there any barriers or misconceptions? What were they? How were they clarified or addressed?

Now have the participants perform

After the role play, ask the discussion questions and record participant responses:

If time permits, have participants perform the third role play.

5. *Summary and Wrap-up (5 minutes)*

Ask participants:

In your experience, what are some effective ways to reach postpartum women with information and counseling?

Distribute handouts #13 and #14.



## Key Messages

- √ Approximately two-thirds of women who gave birth in the last year have unmet need for contraception.
- √ Only a very few women (from three to eight percent) state that they want another child within two years.
- √ 40 percent of women in the first year postpartum say they intend to use a family planning method, but are not yet doing so.
- √ Young women and women with HIV have high unmet need for contraception
- √ Postpartum family planning education and counseling for HTSP can help clients:
  - Understand the importance of spacing the next pregnancy by at least 24 months.
  - Decide whether or not to use family planning for HTSP
  - Identify which contraceptive method is best for them
  - Understand how to use the method safely and correctly.
- √ There are a number of opportunities for discussing postpartum family planning and HTSP with women:
  - MCH services, including antenatal, postpartum, postnatal and well-baby care and child survival services
  - Malaria programs
  - Family planning services
  - HIV/AIDS services
  - Community health outreach
  - Many other possibilities

## **Counseling Postpartum Women for HTSP and FP**

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Recent research findings show that a birth to pregnancy interval of at least two years is a low-cost and effective strategy that contributes to efforts to improve the health of women and their children. The postpartum period is a time when women are likely to be receptive to education and counseling that explains how the use of family planning can address some of the concerns they may have about their health and the health of their newborns. Few postpartum women and their partners, however, receive adequate information, education and counseling on how to space or prevent the next pregnancy through the effective use of family planning services.

As was discussed in earlier in the training manual, a focus on healthy timing and spacing of pregnancy helps postpartum and FP programs and services achieve three key outcomes:

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

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

### *A Note about Counseling Women with HIV*

With the increased availability of anti-retroviral therapy (ART), HIV positive women feel healthy enough to be sexually active, and experience a return to fertility. Some HIV positive women may assume that they will not get pregnant again and so do not use FP to space or limit their pregnancies, while others experience problems in obtaining a method either due to stigma around being HIV positive or the fact that HIV and FP services are often provided separately. Postpartum care for HIV positive women provides an opportunity to help women understand the importance of using FP to either adequately space her next pregnancy or prevent an unintended one.

As with any client, it is important to assess the fertility intentions and desired family size of a woman with HIV. Prevention of Mother to Child Transmission of HIV (PMTCT) programs can dramatically decrease the risk of a mother passing on HIV to her baby during pregnancy and delivery. It is important to advise HIV positive women that pregnancy places a heavy burden on her body and overall health, so she should be careful to limit her pregnancies, and space them adequately by using family planning so she has time to recover between pregnancies. It is extremely important for her health and the health of the baby that she attend antenatal care.

Several factors will influence which are the choices of contraceptive methods for postpartum HIV positive women. These factors should be explored during client education and counseling so that the client understands the pros and cons of pregnancy, and makes a plan that ensures her health and safety and that of her family. Counselors must take special care to ensure that women with HIV have complete information and do not feel coerced or pressured into making any reproductive choices or decisions.

**The HTSP Messages**

<p><b>For couples who desire a next pregnancy after a live birth</b></p> <p>For the health of the mother and the baby, wait at least 24 months, but not more than 5 years, before trying to become pregnant again.</p> <p>Consider using a family planning method of your choice during that time.</p>	<p><b>For couples who decide to have a child after a miscarriage or abortion</b></p> <p>For the health of the mother and the baby, wait at least six months before trying to become pregnant again.</p> <p>Consider using a family planning method of your choice during that time.</p>	<p><b>For adolescents</b></p> <p>For your health and your baby’s health, wait until you are at least 18 years of age, before trying to become pregnant.</p> <p>If you are sexually active, consider using a family planning method of your choice until you are 18 years old.</p>
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Most postpartum women and their partners are interested in preventing a too closely spaced pregnancy. Many women would like to delay their next pregnancy for at least two years. A number of women do not want any more children. Data from 27 countries shows that as many as two-thirds of women who gave birth in the last year have unmet need for contraception, yet only 3 to 8% of women say they want another child within the next two years. 40% of women in the first year postpartum intend to use a family planning method, but are not yet doing so.

Good quality family planning information, counseling and services should be included in the range of services offered to postpartum women. All health workers who interact with postpartum women, not just family planning providers, play an important role in ensuring women have access to this information and these services. Health workers should take a holistic approach to their clients that recognizes and addresses their clients' needs, experiences and concerns, and considers the many factors that may influence their reproductive health choices, decisions and behaviors. This comprehensive approach will contribute to building a better rapport with clients and will promote open discussion of client issues, choices and decisions to use FP for HTSP.

The effectiveness of communication and the quality of counseling are critical components of FP service delivery that contribute to the successful adoption and continued use of FP. Providers must give accurate information on available FP methods, and support clients to make a decision on whether or not to use FP to time, space or limit their pregnancies.

**Interpersonal Communication**

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

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

To communicate effectively, the health care provider should:

- listen carefully to what clients have to say and notice how they say it
- convey interest, concern, and friendliness;
- use words that the client understands;
- encourage the client to ask questions and express any concerns;
- ask questions that encourage clients to express their needs;
- ask only one question at a time and wait with interest for the answer;
- treat each client as an individual;
- keep silent sometimes and give clients time to think, ask questions, and talk;
- every now and then, repeat what you have heard to make sure that you understand what the client is saying;
- sit or stand comfortably and avoid distracting movements; and
- look directly at clients when they speak.

### **Quality Counseling**

Good quality counseling will help a client to:

- decide whether or not to use family planning;
- decide whether or not to practice HTSP or to limit pregnancy altogether;
- choose a method that is personally and medically appropriate; and
- understand how to use the method correctly.

Good counseling considers the multiple and sometimes complex factors that influence clients' decision-making, including age, gender, marital status, level of education, relationships with partners and other family members, socio-economic status, religious beliefs, cost and access to family planning services, fertility intentions, desired family size, and many more.

### **What Are Important Points to Address During Postpartum Family Planning Counseling?**

As part of general postpartum education and counseling, the provider should:

- Discuss the benefits of healthy timing and spacing of pregnancy.
- Inform the client about FP methods that she can use to practice HTSP, and which ones are suitable for breastfeeding and non-breastfeeding mothers, including LAM.
- Discuss the benefits of condoms for dual protection against pregnancy and HIV/STIs.
- Address any general concerns about postpartum family planning that client may have.

If the client is not ready to choose a family planning method, reinforce the benefits of LAM for the client who can meet the LAM criteria, as well as the benefits of HTSP. Remind her that LAM is only effective for the first six months postpartum as long as the client is only breastfeeding. Schedule a time for follow-up.

If a postpartum client is ready to choose a family planning method, the provider should:

- Ensure the client has enough information on the method she has chosen.
- Instruct the client on how to use the method.
- Explain when the client should begin using the method.
- Explain the common side effects of the method she has chosen. Reassure the client that side effects usually resolve or go away after a few months. Discuss what to do if she has problems with the method
- As appropriate, reinforce information on the use of FP methods by breastfeeding women
- As needed, refer clients for FP methods you cannot provide, such as IUDs, injectables, implants or sterilization.
- If you cannot provide her chosen method, provide the client with a back-up method until she can obtain her preferred method.

Counseling should be sensitive and responsive to the needs of women at different points in her life cycle when helping women make decisions to use FP and practice HTSP. Most healthy women can use any method of contraception, but as she moves through the different stages of her reproductive life her contraceptive needs may change over time, based on factors such as her fertility intentions, desired family size and health status. Adolescents, postpartum and postabortion women, breastfeeding women, women over the age of 35 and women nearing menopause are groups with special contraceptive and counseling needs.

For example:

- An adolescent of 16 may see herself as eventually having four children (desired family size) but has no intention of becoming pregnant right now (fertility intentions).
- A young married woman may feel conflicting emotions over becoming pregnant due to her own feelings and pressure from her husband and family (fertility intentions). She may fear opposition to family planning from her husband or mother-in-law, and may be unclear about her desired family size.
- A woman who is postpartum may intend to have at least two more children (desired family size) but does not want to become pregnant right away (fertility intentions).
- A woman who has just had a miscarriage may want to become pregnant again as soon as possible (fertility intentions)
- A woman of 30 may have had all the children she intends to have and does not want to become pregnant again (desired family size, fertility intentions).
- A woman of 45 who is approaching menopause is sure that she cannot become pregnant.
- A 27 year-old HIV positive woman with two children plans to have a third child, but would like to wait until her youngest child turns three before becoming pregnant.

All of these women have distinct situations, intentions and needs that must be addressed in educating and counseling women on the healthiest and safest options that are available to them in terms of HTSP and FP use.

While most counseling occurs between a provider and a client, in some situations it may be useful-indeed critical-to involve a woman's husband or other important decision-maker, such as her mother-in-law, in counseling. Couples' or group counseling that addresses FP and HTSP provides men and other family members with important information on the health, social and

economic benefits of HTSP and FP, and an opportunity to discuss how they can act to protect their health and the health of their wives, daughters and children.

Family planning clients differ, their situations differ, and they need different kinds of help at different stages of their life. There is no set script for counseling men and women about HTSP. There are however, certain key messages and tasks that counselors should keep in mind as presented in Table 3:

**Table 3: Family Planning Counseling Strategies for Different Client Types**

Client Type	Usual Counseling Tasks
<b>Returning clients with no problems</b>	<ul style="list-style-type: none"> <li>• Provide more supplies or routine follow-up.</li> <li>• Ask a friendly question about how the client is doing with the method.</li> <li>• Assess her intentions around becoming pregnant to ensure she continues to practice HTSP, where appropriate for her situation.</li> </ul>
<b>Returning clients with problems</b>	<ul style="list-style-type: none"> <li>• Understand the problem and help resolve it—whether the problem is side effects, trouble using the method, an uncooperative partner, or another problem.</li> <li>• Help her choose another method, if she so desires, so that she does not discontinue the use of her method and risk an unplanned or closely spaced pregnancy.</li> <li>• Remind her of the importance of practicing HTSP.</li> </ul>
<b>New clients with a method in mind</b>	<ul style="list-style-type: none"> <li>• Check that the client's understanding of the method is accurate.</li> <li>• Support the client's choice, based on your assessment of the client's situation and if the client is medically eligible.</li> <li>• Discuss how to use method and how to cope with any side effects.</li> <li>• Discuss the health benefits of HTSP specific to her situation (e.g. delay to age 18, spacing Postpartum or post abortion) and how FP can help her maintain her health and ensure healthy pregnancies.</li> </ul>
<b>New clients with no method in mind</b>	<ul style="list-style-type: none"> <li>• Discuss the client's situation, plans (such as fertility intentions, desired family size), and what is important to her about a method.</li> <li>• Help the client consider methods that might suit her particular situation. If needed, help her reach a decision.</li> <li>• Support the client's choice, give instructions on use, and discuss how to cope with any side effects.</li> <li>• Discuss the health benefits of HTSP specific to her situation (e.g. delay to age 18, spacing Postpartum or post abortion) and how FP can help her maintain her health and ensure healthy pregnancies.</li> </ul>

## Using the GATHER Method for Counseling on HTSP and FP

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Providers can effectively counsel clients on HTSP and FP by following the GATHER<sup>13</sup> method which stands for **Greet** the client, **Ask** them about themselves, **Tell** them about FP methods, **Help** them choose a method, **Explain** how to use the chosen method, and **Refer or Return** for follow-up.

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

Counseling should begin with information about the benefits of HTSP, and how the use of FP can help her achieve that benefit. Next, the provider should explore if there are any obstacles that the client might face that would prevent her from using FP to practice HTSP, as well as whether or not there is support from her husband and/or family for her desire to space her children. The provider should keep in mind that in some cases, women may not have control over the timing and spacing of their pregnancies as this may be dictated by traditional norms and practices.

The use of the GATHER method encourages providers to consider the personal characteristics and situation of a client that might influence her ability to effectively use FP for HTSP. As has been previously stated, however, counseling should always be tailored to the client. The GATHER method has been adapted here to incorporate important information on HTSP for postpartum women.

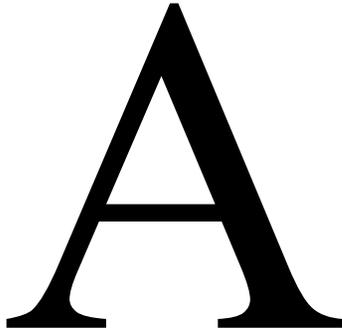
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<sup>13</sup> Rinehart, W., Rudy, S. and Drennen, M. GATHER Guide to Counseling, Population Reports, Series J, No.48, Baltimore, Johns Hopkins University School of Public Health, Population Information Program, December 1998.

# G

## **Greet the client in a friendly way.**

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

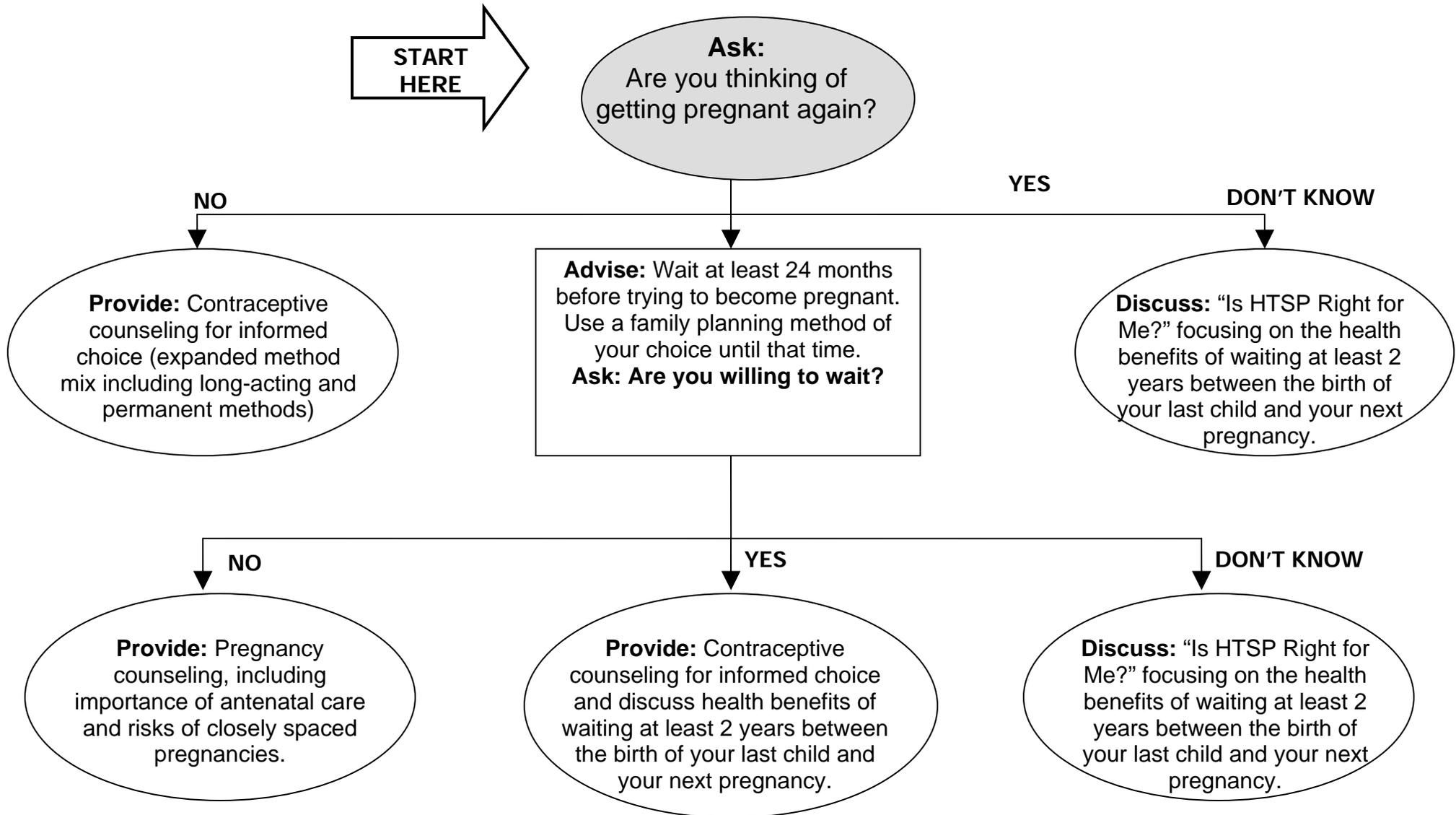


**Ask the client why she has come in for a visit.**

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

- If the client is new, obtain a history, including the client's:
  - ❖ Age
  - ❖ Marital/union status
  - ❖ Basic medical information
  - ❖ Number of pregnancies and when
  - ❖ Number of births and when
  - ❖ Number and ages of living children
  - ❖ Family planning use for delaying, spacing or limiting pregnancies, now and in the past
- Probe for fertility intentions using Fertility Intention Question Tree (Figure 5). Explain that you are asking for this information to help the client make an informed choice about delaying, spacing and/or limiting a future pregnancy and to help her identify the most suitable family planning method.
- Keep questions simple and brief. Look at your client as you speak.
- Help clients talk about their needs, wants, doubts, concerns, or questions they may have about HTSP, FP and pregnancy
- Ensure that the client understands what you have to say. Encourage clients to ask questions.
- If the client is not new, ask her if anything has changed since her last visit.

Figure 5: Fertility Intention Question Tree for Postpartum Women



T

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

- As needed, probe to determine whether the client is more interested in becoming pregnant again or in limiting her childbearing.
  - ❖ For postpartum women, explain why spacing pregnancies at least two years is beneficial. Inform her how long a woman should wait from her last birth to her next pregnancy, if she wants to become pregnant again.
  - ❖ For postabortion or post-miscarriage women, explain that if she wants to become pregnant again, she should delay getting pregnant for at least six months.
  - ❖ For adolescents, explain that it is important to wait until she is 18 before becoming pregnant.
- Explain the potential risks of not practicing HTSP.
- If the client is interested in HTSP, discuss available modern and fertility awareness based methods of family planning that she can use to practice HTSP, including LAM based on the client's fertility intentions. Inform your client about which FP methods are available and where she can obtain them, and ask if there are any methods that interest them.
- Ask your client what she already knows about the methods that interest her. Correct any misinformation.
- Briefly describe each method that the client wants to hear about. Talk about:
  - ❖ Effectiveness
  - ❖ How to use the method
  - ❖ Advantages and disadvantages, including information on return to fertility
  - ❖ Possible side effects and complications
- Use samples and other audiovisual materials, if available.
- If client is not interested in HTSP and wants to become pregnant again, provide counseling on the importance of antenatal care.
- If client is undecided, probe reasons for not spacing and discuss further. As appropriate use the information from Table 4 (below) **Is HTSP Right for Me?**

## GATHER FOR HTSP

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<b>Table 4: IS HTSP RIGHT FOR ME?</b>	
<b>COMMON REASONS CITED BY WOMEN FOR NOT PRACTICING HTSP AND POSSIBLE RESPONSES</b>	
<b>Reasons for not waiting before youngest child is at least 2 years old:</b>	<b>Possible Responses</b>
<ul style="list-style-type: none"> <li>• It is best to have the children one after the other while young so the mother is strong enough to raise them.</li> </ul>	<ul style="list-style-type: none"> <li>• Even young mothers can be stressed and weakened by closely spaced pregnancies.</li> </ul>
<ul style="list-style-type: none"> <li>• It is best to have children one after the other so that they can have a companion close to their age with whom they can play.</li> </ul>	<ul style="list-style-type: none"> <li>• Children closely spaced together may demand more attention from the mother.</li> </ul>
<ul style="list-style-type: none"> <li>• It is easier to raise two children close to each other in age, because they can share clothes, toys, and the mother's time. It also saves money.</li> </ul>	<ul style="list-style-type: none"> <li>• All mothers need time to regain their energy and health after childbirth to be ready for a healthy next pregnancy.</li> </ul>
<ul style="list-style-type: none"> <li>• It is more convenient to complete the family quickly and then go for permanent methods like surgical sterilization</li> </ul>	<ul style="list-style-type: none"> <li>• The mother can give the last-born child all the needed attention to grow healthy, be well fed, and loved. If she is exhausted from a new pregnancy, she may not be able to give the last-born child enough attention.</li> </ul>
<ul style="list-style-type: none"> <li>• If a woman waits too long, she will be too old to have another child.</li> </ul>	<ul style="list-style-type: none"> <li>• It is better for the whole family if the mother and children are healthy, which may not happen if the births are closely spaced.</li> </ul>
<b>Common reasons for not practicing HTSP:</b>	<b>Possible Responses</b>
<ul style="list-style-type: none"> <li>• Her religion does not allow her to use FP.</li> </ul>	<ul style="list-style-type: none"> <li>• You can use fertility-based awareness methods and other natural methods to plan your family. You can also practice LAM by breastfeeding.</li> </ul>
<ul style="list-style-type: none"> <li>• Her husband is not interested in discussing family planning or pregnancy spacing and/or he feels that it is her responsibility, not his.</li> </ul>	<ul style="list-style-type: none"> <li>• Pregnancy spacing is a joint responsibility and there are many economic, social and emotional advantages to spacing children.</li> </ul>
<ul style="list-style-type: none"> <li>• The man's virility may be questioned if his wife does not become pregnant quickly.</li> </ul>	<ul style="list-style-type: none"> <li>• A responsible man knows that his family's health is important, and he is willing to take steps to ensure that his family is healthy by planning and spacing his children.</li> </ul>

**Table 4: IS HTSP RIGHT FOR ME?**

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

<ul style="list-style-type: none"> <li>The woman’s fertility may be questioned if she is not able to become pregnant quickly.</li> </ul>	<ul style="list-style-type: none"> <li>While it is important to acknowledge the concerns and expectations of her husband and family, they must also understand the risks of closely spaced pregnancies to the health of the woman, her current and future children.</li> </ul>
<b>Reasons for not waiting until age 18:</b>	<b>Possible Responses</b>
<ul style="list-style-type: none"> <li>It is best to have children while young so the mother is strong enough to raise them.</li> </ul>	<ul style="list-style-type: none"> <li>Married adolescents need time to physically and psychologically mature so that they are prepared for pregnancy and childbirth. Delaying the first child until a young woman is at least 18 increases the chances of having a healthy pregnancy and a healthy child.</li> </ul>
<ul style="list-style-type: none"> <li>It is more convenient to complete the family quickly and then go for permanent methods like surgical sterilization.</li> </ul>	<ul style="list-style-type: none"> <li>Completing a family can be done quickly and safely after the age of 18, after which permanent methods and surgical sterilization are options.</li> </ul>
<ul style="list-style-type: none"> <li>If a woman waits too long, she will be too old to a child.</li> </ul>	<ul style="list-style-type: none"> <li>Waiting until you are 18 is not too long and women can have healthy children safely for many years after that.</li> </ul>
<ul style="list-style-type: none"> <li>Members of her family, such as her husband or mother-in-law are pressuring her to have a child. The family may pressure the woman to get pregnant as soon as she marries, even if she is very young. In many cases, it is important to demonstrate her fertility and/or produce a male child as soon as possible.</li> </ul>	<ul style="list-style-type: none"> <li>While it is important to acknowledge the concerns and expectations of her husband and family, women must also understand the risks of too early pregnancies to the health of the mother and her future children.</li> </ul>
<b>Reasons for not waiting after a miscarriage or abortion:</b>	<b>Possible Responses</b>
<ul style="list-style-type: none"> <li>It is more convenient to complete the family quickly and then go for permanent methods like surgical sterilization.</li> </ul>	<ul style="list-style-type: none"> <li>Waiting 6 months will not hinder your time to complete your ideal family size, after which permanent methods and surgical sterilization are options.</li> </ul>
<ul style="list-style-type: none"> <li>Members of her family, such as her husband or mother-in-law are pressuring her to have a child. The family may pressure the woman to get pregnant as soon as possible. In many cases, it is important to demonstrate her fertility and/or produce a male child.</li> </ul>	<ul style="list-style-type: none"> <li>While it is important to acknowledge the concerns and expectations of her husband and family, women must also understand the risks of too early pregnancies to the health of the mother and her future children.</li> </ul>

# H

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

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

# E

## **Explain how to use the method.**

- After the client has chosen a method, give her supplies, if appropriate.
- If the method cannot be given immediately, tell the client how, when, and where it will be provided. Provide a back up method, such as condoms.
- For some methods, such as voluntary surgical contraception, the client may have to sign a consent form which states that the client wants the method, has been given information about it, and understands the information (please refer to the procedures for voluntary sterilization in your country). Help the client understand the consent form.
- Ask the client to repeat the instructions on using and/or obtaining her method. Listen carefully to make sure she remembers and understands.
- Describe any possible side effects and warning signs. Clearly inform the client what to do if they occur.
- Ask the client to repeat this information and clarify as needed.
- If possible, give the client printed material about the method.
- Inform the client when to come back for a follow-up visit as needed, (e.g. for resupply, check up, etc)
- Remind the client that she should use the method for at least two years after the birth of her last child (for postpartum women); or for at least six months following a miscarriage or abortion; or until she is at least 18 years old; or permanently if she wants no more children.
- Inform the client to come back sooner if she wishes, or if side effects or warning signs occur.

**R**

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

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

## Session 6: Postpartum Family Planning: Involving Men<sup>14</sup>

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### Session Objectives:

By the end of the session, participants will

- Examine their own comfort level in counseling and communicating with men on postpartum FP
- Discuss biases against and in favor of men
- Articulate characteristics of effective providers of services to men



### Time

90 minutes



### Materials

- Flip chart and markers
- Power point presentation/transparencies
- Handout #15: Provider comfort when counseling men



### Advance Preparation

- Make copies of handouts

### Introduction

Postpartum family planning services usually focus on women. However, men play an important role in women's decisions to use FP for HTSP. Many couples use a contraceptive method that relies on the man's active cooperation, such as condoms, vasectomy, withdrawal or Standard Days Method.

Communication between partners and with health care providers is an important component of contraceptive use. But cultural barriers may prevent men and women from talking about sexuality as well as contraception. Also, providers may be uncomfortable and/or lack of training on how to discuss FP with men. Health facility procedures and protocols may discourage men from using services and men's own attitudes towards reproductive health may limit their involvement.

The postpartum period is a time when men may come in contact with the health care system with their wives and babies. Providers can make an effort to include men in discussions around the importance of postpartum family planning and benefits of HTSP for women, babies and men.

This session will help us examine some of the discomfort or biases we may have related to providing men with RH/FP information and counseling and help us think of some ways to better include men as part of postpartum family planning counseling and services.

### Training Activities

#### 1. *Determining Provider Comfort When Counseling Men*

Distribute Handout #15, Provider comfort when counseling men, to participants. Explain that this will help participants begin to think about how comfortable they feel in counseling and communicating with men.

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<sup>14</sup> This activity was adapted from EngenderHealth's Counseling and Communicating with Men—Trainer's Resource Book

Ask the participants to read each statement and check the box that corresponds to their opinion. Explain that they do not need to write their names, and that you will not be collecting the papers. No one will see their answer and they should respond honestly. Allow 10 minutes to complete.

Discuss the questions below.

- How did it feel to express your opinion about these statements?
- Which statements (if any) were easier to express an opinion about? Which were harder? Why?
- How do you think your values, attitudes and biases about men might affect your ability to provide FP counseling to men whose wives are postpartum?
- What fears, if any, do you have about working with male clients?

## 2. *Provider Bias Brainstorm*

On one sheet of flip chart paper, write “Provider Bias Against Men.” On the second sheet of flip chart paper, write “Provider Bias in Favor of Men.”

Explain to participants that they have all seen examples of provider and health care facility bias. During this activity, we will brainstorm some ways in which providers and health care facilities are biased against or in favor of men.

Explain that bias AGAINST men involves attitudes or behaviors that might discourage men from seeking health information or services. Ask the following to start the brainstorming process:

- What are some beliefs that providers may have about men that affect how they interact with or provide professional and respectful RH/FP information to men?
- What are some examples of ways that staff at a health care facility might give poor treatment to men?
- What are some examples of how a health care facility’s protocols or the environment might be unwelcoming to men?

Once you have generated a list of provider and facility biases against men, now look at provider and facility biases that FAVOR men. Explain that this type of bias involves service providers favoring, men, giving preferential treatment to men, or treating male clients as better than female. Ask the following questions to begin:

- What are some beliefs that providers may have about men that may lead them to give preferential treatment to men?
- What are some examples of how staff at a health care facility give preferential treatment to men?
- What are some examples of a health care facility’s protocols or the environment might lead to men receiving preferential treatment?

Close the brainstorm by discussing the questions below:

- How did it feel to discuss bias about male clients with other staff?
- After looking at the list of biases AGAINST men, would you add any other examples?
- After looking at the list of biases in FAVOR of men, would you add any other examples?

### 3. *Group Activity*

Write the title “Create an Effective Service Provider” on a sheet of flip chart paper. Write the following questions under the title:

- What are the characteristics of an effective service provider for men?
- What knowledge, attitudes and skills does this person have?
- How does this person relate to men?

Draw an outline of a person under the questions.

Tell participants that many people are unsure about what makes a person effective in counseling men to support postpartum FP and HTSP. In this activity, we will work in small groups to “create” a drawing of a provider who is comfortable discussing postpartum FP and HTSP with men.

Have participants break into small groups of 4 – 5 people. Give each group a sheet of flip chart paper and markers. Have participants start by drawing an outline of a person.

Participants should then discuss characteristics this person or provider has or needs to be able to discuss postpartum FP and HTSP with men. Include this information on your drawing of the service provider. Be creative and use pictures, words and symbols. You may start by asking yourselves the following questions:

- What is this person like?
- What knowledge does this person have?
- What attitudes towards men does this person have?
- What skills does this person have that will help educate and counsel men?
- What training has this person had?

After about 15 minutes, reconvene the larger group. Each small group should select a reporter to present their drawing to the larger group.

Close by discussing the following:

- What similarities or themes do you see in the drawings?
- When you think about yourself as a service provider who is trying to better involve men in postpartum FP and HTSP, how do you feel when you see the drawings?
- Is it easy to measure up to what you have created? (Remind participants that these drawings are “ideal” and no one can live up to this 100%).
- As you look at the drawings, is there one characteristic that you feel describes you well? Which characteristic do you feel you may need to improve?
- What steps can you take to become more like the ideal provider so you can better involve men in postpartum FP and HTSP education and counseling?



## Key Messages

- √ Men are important to efforts to help women better use postpartum FP to time and space their next pregnancy, or to limit pregnancy altogether.
- √ In addition to examining some of our personal values, attitudes and biases, we should also consider the environments where postpartum FP counseling and services are being provided. What are some things we can do to make our health facilities more “male friendly?”

## Session 7: HTSP for Postpartum Women: Action Planning

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### Session Objective:

Participants will develop action plans to apply new learning in the workplace



### Time

90 minutes



### Materials

Tool #5 Action Planning Matrix

### Training Activities

#### 1. *Small groups (30 minutes)*

Divide participants into groups of three or four. If possible, group participants based on their workplace setting so that they can conduct group action planning

Ask participants to identify at least three areas in their daily work where they can integrate FP and HTSP information and services for postpartum women, and have them complete the action planning matrix.

Allow participants 30 minutes to complete their action planning.

#### 2. *Group discussion (55 minutes)*

Have participants present their action plans to the larger group. Facilitate feedback and help participants think through their action plans completely and realistically so that they can implement them effectively.

#### 3. *Summary and Wrap-up*

Summarize common themes that emerged from the action planning. Encourage participants to work together and pool resources to implement their proposed activities.

## Session 8: Evaluation and Closing

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### Session Objectives

Participants will evaluate the training and offer their feedback.



### Time

90 minutes



### Materials

- Post test
- Training evaluation forms
- Certificates of Completion



### Advance Preparation

- Make photocopies of post-test, evaluation, and certificates.
- Make sure all certificates of participation are signed and that names are spelled correctly.

### Activity

1. Thank participants for attending the final session. This session will provide important feedback to both the participant and the trainers.
2. Administer Post Test (30 minutes)
3. Administer evaluation (15 minutes)

*Closing Ceremony (45 minutes)*

Presentation of certificates of completion

Summary and Wrap-up

## **Training Tools**

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### **List of Training Tools**

1. Pre-test/post-test
2. Pre-test/post-test answer key
3. Evaluation Form
4. FP for HTSP Checklist
5. Action Planning Matrix
6. Certificate of Completion Template

## **TRAINING TOOL #1: PRE/POST TEST - FOR PARTICIPANTS**

- 1. The extended postpartum period lasts up to:**
  - a. six weeks after delivery
  - b. six months after delivery
  - c. one year after delivery
  - d. two years after delivery
  
- 2. What is the meaning of the term "unmet need for family planning"?**
  - a. When a woman has no need for family planning.
  - b. When couples do not want to use contraceptives but the health worker insists that they need them.
  - c. The proportion of currently married women of reproductive age who are not using contraception but would like to either postpone the next pregnancy or to prevent unwanted pregnancy.
  - d. When women understand that they need to use a birth spacing method, but their partners do not agree, so they use it without their partners' knowledge.
  
- 3. What are the benefits of using family planning?**
  - a. Reduces unwanted pregnancies
  - b. Reduces maternal death and illness
  - c. Prevents infant death and illness
  - d. Enables women to space their pregnancies at least 24 months apart
  - e. All of the above statements are correct
  
- 4. Which of the following statements about young mothers (i.e., those between the ages of 10-18 years of age) is TRUE:**
  - a. They are physically and emotionally prepared to deliver a baby
  - b. They and their babies are at greater risk for death or disability from complications, such as obstructed labor, fistula, premature birth or low birth weight than women over 20
  - c. Younger mothers are healthier mothers
  - d. All of the above statements are true.
  
- 5. Which of the following statements are true?**
  - a. HTSP promotes the best health outcomes for women, newborns, and infants, through the practice of recommended pregnancy spacing
  - b. HTSP promotes healthier families.
  - c. HTSP helps reduce death and illness in mothers and infants
  - d. All of the above

- 6. How old should a woman be before she has her first pregnancy?**
- a. At least 18 years old
  - b. At least 12 years old
  - c. No more than 15 years old
- 7. Is the Lactational Amenorrhea Method an appropriate FP method to begin immediately after delivery? Circle the correct answer.**
- YES NO
- 8. How long should a couple wait from their last birth before attempting another pregnancy?**
- a. At least two years
  - b. Six months
  - c. One year
  - d. There is no need to wait
- 9. Postpartum family planning counseling can be provided as part of which following services?**
- a. Antenatal care
  - b. Postpartum care
  - c. Well baby clinics
  - d. Family planning services
  - e. HIV/AIDS services
  - f. Community health outreach
  - g. All of the above
- 10. Postpartum education and counseling should include:**
- a. Information about the benefits of HTSP, risks associated with closely spaced pregnancies, and range of contraceptive methods that can be used postpartum to space.
  - b. Helping women to decide whether or not they want to use a family planning method, and if they do, helping them to choose the best time to start a method.
  - c. Answering questions or concerns that women and men may have regarding HTSP and family planning.
  - d. All of the above
- 11. Following delivery, non-breastfeeding women experience a period of infertility:**
- a. which may last up to four weeks
  - b. which may last for over one year
  - c. which lasts exactly six weeks
  - d. which lasts about six months

- 12. The type of contraceptive method that a postpartum woman can use depends upon:**
- a. The mother's age
  - b. Her health
  - c. When the mother regains her health after the delivery
  - d. A woman's breastfeeding status and the length of time since delivery
  - e. The age of the baby
- 13. Women who use the Lactational Amenorrhea Method (LAM) to prevent pregnancy should:**
- a. Have a baby who is less than six months old
  - b. Has not begun menstruating yet
  - c. Be only breastfeeding her baby
  - d. All of the above
- 14. Which family planning method(s) can be initiated immediately postpartum by breastfeeding women? Circle all that apply.**
- a. Cycle beads
  - b. Progestin-only injectables
  - c. Combined oral contraceptives
  - d. Lactational Amenorrhea Method (LAM)
- 15. The World Health Organization recommended that the schedule of postpartum visits correspond to the times of greatest need for a mother and her infant, which are:**
- a. At 6 hours, 6 days, 6 weeks, and 6 months postpartum but it is important to be flexible, as postpartum care must be based on the needs of the mother.
  - b. At 6 week as this is the only time postpartum women need critical care and advice on birth spacing options.
  - c. At 2 days, 2 week and six months.
  - d. At 2 weeks and 2 months.

## TRAINING TOOL #2: PRE-/POST-TEST - ANSWER KEY

### Introduction to Community-Based Postpartum Family Planning

Correct answers are in bold type.

### Introduction to Community-Based Postpartum Family Planning

1. **The extended postpartum period lasts up to:**
  - a. six weeks after delivery
  - b. six months after delivery
  - c. one year after delivery**
  - d. two years after delivery
  
2. **What is the meaning of the term "unmet need for family planning"?**
  - a. When a woman has no need for family planning
  - b. When couples do not want to use contraceptives but the health workers insists that they need them
  - c. The proportion of currently married women of reproductive age who are not using contraception but would like to either postpone the next pregnancy or to prevent unwanted pregnancy**
  - d. When women understand that they need to use a birth spacing method, but their partners do not agree, so they use it without their partners' knowledge
  
3. **What are the benefits of using family planning?**
  - a. Reduces unwanted pregnancies
  - b. Reduces maternal death and illness
  - c. Prevents infant death and illness
  - d. Enables women to space their pregnancies at least 24 months apart
  - e. All of the above statements are correct**
  
4. **Which of the following statements about young mothers (i.e., those between the ages of 10-18 years of age) is TRUE:**
  - a. They are physically and emotionally prepared to deliver a baby
  - b. They and their babies are at greater risk for death or disability from complications, such as obstructed labor, fistula, premature birth or low birth weight than women over 20**
  - c. Younger mothers are healthier mothers
  - d. All of the above statements are true.

5. **Which of the following statements are true?**
- a. HTSP promotes the best health outcomes for women, newborns, and infants, through the practice of recommended pregnancy spacing
  - b. HTSP promotes healthier families.
  - c. HTSP helps reduce death and illness in mothers and infants
  - d. All of the above**
6. **How old should a woman be before she has her first pregnancy?**
- a. At least 18 years old**
  - b. At least 12 years old
  - c. No more than 15 years old
7. **Is the Lactational Amenorrhea Method an appropriate FP method to begin immediately after delivery? Circle the correct answer.**
- YES  NO
8. **How long should a couple wait from their last birth before attempting another pregnancy?**
- a. At least two years**
  - b. Six months
  - c. One year
  - d. There is no need to wait
9. **Postpartum family planning counseling can be provided as part of which following services?**
- a. Antenatal care
  - b. Postpartum care
  - c. Well baby clinics
  - d. Family planning services
  - e. HIV/AIDS services
  - f. Community health outreach
  - g. All of the above**
10. **Postpartum education and counseling should include:**
- a. Information about the benefits of HTSP, risks associated with closely spaced pregnancies, and range of contraceptive methods that can be used postpartum to space.
  - b. Helping women to decide whether or not they want to use a family planning method, and if they do, helping them to choose the best time to start a method.
  - c. Answering questions or concerns that women and men may have regarding HTSP and family planning.
  - d. All of the above**

11. **Following delivery, non-breastfeeding women experience a period of infertility:**
- a. **Which may last up to four weeks**
  - b. Which may last for over one year
  - c. Which lasts exactly six weeks
  - d. Which lasts about six months
12. **The type of contraceptive method that a postpartum woman can use depends upon:**
- a. The mother's age
  - b. Her health
  - c. When the mother regains her health after the delivery
  - d. **A woman's breastfeeding status and the length of time since delivery**
  - e. The age of the baby
13. **Women who use the Lactational Amenorrhea Method (LAM) to prevent pregnancy should:**
- a. Have a baby who is less than six months old
  - b. Has not begun menstruating yet
  - c. Be only breastfeeding her baby
  - d. **All of the above**
14. **Which family planning method(s) can be initiated immediately postpartum by breastfeeding women? Circle all that apply.**
- a. Cycle beads
  - b. Progestin-only injectables
  - c. Combined oral contraceptives
  - d. **Lactational Amenorrhea Method (LAM)**
15. **The World Health Organization recommended that the schedule of postpartum visits correspond to the times of greatest need for a mother and her infant, which are:**
- a. **At 6 hours, 6 days, 6 weeks, and 6 months postpartum but it is important to be flexible, as postpartum care must be based on the needs of the mother.**
  - b. At 6 week as this is the only time postpartum women need critical care and advice on birth spacing options.
  - c. At 2 days, 2 week and six months.
  - d. At 2 weeks and 2 months.

**TRAINING TOOL #3: PARTICIPANT EVALUATION FORM**

Trainer: \_\_\_\_\_

Location: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Instructions: Please complete the following evaluation of the training in which you just participated. Complete all sections of this evaluation form. Use the reverse side for additional comments. We are interested in learning about your views of the training sessions, and your response will let us know how to improve future training and provide us with information about what other topics you would like to see addressed.

1. Overall Evaluation

Please circle the choice that best reflects your overall evaluation of this training:

5	4	3	2	1
Very Good	Good	Fair	Poor	Very poor

Other Comments:

2. This training has developed my knowledge on the subject of counseling on healthy timing and spacing of pregnancy (HTSP) and family planning in the postpartum period.

5	4	3	2	1
Completely agree	Mostly Agree	Somewhat Agree	Somewhat Disagree	Completely Disagree

Other Comments:

3. This training has helped me develop skills in counseling on healthy timing and spacing of pregnancy (HTSP) and family planning in the postpartum period

5	4	3	2	1
Completely agree	Mostly Agree	Somewhat Agree	Somewhat Disagree	Completely Disagree

Other Comments:

4. How well did the training meet your expectations?

5	4	3	2	1
Very Good	Good	Fair	Poor	Very poor

5. Which three sessions were the most useful, and why?

- a.
- b.
- c.

6. Which three sessions were the least useful, and why?

- a.
- b.
- c.

7. Did the training methods help you learn?

5	4	3	2	1
Very well	Somewhat well	Neutral	Not well	Not at all

Other Comments:

8. What could have improved the training? Tick as appropriate.

- Use of more realistic examples and applications
- More time to become familiar with the technical information that was shared
- More time to practice skills and techniques
- More group interaction
- Better training activities
- Concentration on a more specific topic
- Consideration of a more comprehensive topic

Other Comments:

9. What three things could have been done to make the training more effective for you?

- a.
- b.
- c.

Thank you for your feedback!

**TRAINING TOOL #4: CHECKLIST FOR COUNSELING POSTPARTUM WOMEN ON FP AND HTSP**

<b>Checklist for Counseling Postpartum Women on FP and HTSP</b>			
<b>TASK</b>		<b>YES</b>	<b>NO</b>
1.	Greet client politely and give her or him your full attention.		
2.	Inform client that you will not tell others what they say during the discussion and conduct the counseling for HTSP and FP.		
3.	Explain what will happen during the visit.		
4.	Obtain relevant client information and history (e.g. name, age, marital status etc.), her basic medical information, pregnancy/reproductive history, contraceptive use		
5.	Probe for fertility intentions. Explain why you are asking these questions		
6.	Allow client to talk about her needs, wants, concerns, etc regarding pregnancy, child spacing, FP, etc		
7.	Ask client what she knows about Healthy Timing and Spacing of Pregnancy.		
8.	Ensure client understands what you have to say.		
9.	Based on client's fertility intentions, determine if client is interested in becoming pregnant again or if she wants to limit her family size.		
10.	Explain HTSP, including the three HTSP messages.		
11.	Explain the benefits of HTSP and the risks of not practicing HTSP		
12.	If the client is interested in HTSP, discuss the use of FP for HTSP		
13.	Ask client(s) which family planning methods she knows and inquire what s/he knows about these methods.		
14.	Inform client about which family planning methods are available, including fertility-based methods.		
15.	Help the client match her needs and preferences with an FP method to delay, space or limit.		
16.	Briefly describe each method that the client wants to hear about, and describe any side effects and inform client what s/he needs to do if any side effects occur.		
17.	Ask the client if there is a method she would like to use. Where appropriate help her make a decision.		
18.	As appropriate, ask the client about her partner's preferences.		
19.	Address any concerns or questions the client might have about using FP for HTSP. Reinforce the benefits of HTSP		
20.	Explain how to use the method. Ask client to repeat the instructions and check if there is anything she does not understand. Use samples and audiovisuals.		
21.	Check to make sure client has made a clear decision.		
22.	Ask the client if there is anything she does not understand. Clarify and correct any misunderstanding about the methods.		
23.	If the client wants to use a method that is not appropriate or safe for her, clearly explain why she should not use this method. Help her select another method.		

24.	If client is undecided, probe reasons for not wanting to space and discuss further.		
25.	Give client supplies, if appropriate.		
26.	Provide written materials if possible		
27.	If the method cannot be given immediately, tell her how, when and where it will be provided. Provide a back up method such as condoms.		
28.	For some methods, such as voluntary surgical contraception, she may need to sign a consent form. Make sure the client understands the consent form.		
29.	Inform the client when to return for a visit (e.g. resupply, check up).		
30.	Invite the client to return sooner if she wishes to address any problems or for additional information.		
<b>FOR POSTPARTUM CLIENTS, with children less than six months of age, also ask the following:</b>			
31.	Inform client about return to fertility following a full-term birth.		
32.	Inform client about lactational amenorrhea method and how it can be used for pregnancy spacing.		
33.	Inform client which FP methods can be safely used during Postpartum period.		
34.	Identify with the client which methods are appropriate for breastfeeding mothers and for non-breastfeeding mothers		
35.	Remind the mother to use FP for at least two years after the birth of her last child.		
36.	Reinforce importance of HTSP for health of mother and baby.		
<b>FOR ADOLESCENT CLIENTS, also advise them</b>			
37.	To ensure the healthiest outcomes for both mother and baby, adolescents should wait until they are at least 18 before becoming pregnant		
<b>FOR HIV POSITIVE WOMEN, also advise them</b>			
38.	The use of condoms prevents both pregnancy and HIV		
39.	Family planning helps limit the spread of HIV by preventing unintended pregnancies among HIV + women, which decreases the likelihood of HIV infection in children.		
40.	Women who are on ARVs can safely use most contraceptive methods		
41.	HIV + women who want to have children can increase the chances of having a healthy pregnancy through improved use of HTSP and FP.		
42.	It is very important that HIV + women who want to become pregnant seek antenatal care.		

**Training Tool #5: Action Planning Matrix**

**Following the training, participants are expected increase postpartum clients' awareness and use of FP for HTSP.  
To achieve this objective, I plan to implement the following priority activities:**

<b>Service where HTSP/FP can be integrated</b>	<b>What will I do to integrate FP/HTSP?</b>	<b>What sources of support and resources will I need?</b>	<b>Who else will I need to involve?</b>	<b>When will I complete this activity?</b>	<b>Notes</b>

# Certificate of Completion

This certifies that \_\_\_\_\_

has completed a two-day training in providing family planning and healthy timing and spacing of pregnancy information, education and services to postpartum women.

Signed \_\_\_\_\_

Date \_\_\_\_\_

Title \_\_\_\_\_

## Training Handouts

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Handout #1	ACCESS - FP Programmatic Framework: Postpartum Family Planning in an Integrated Context
Handout #2	WHO Policy Brief
Handout #3	The HTSP Messages
Handout #4	The HTSP Graphs
Handout #5	HTSP 101
Handout #6	Benefits of HTSP vs Risks if HTSP Is Not Practiced
Handout #7	Adolescent Maternal Mortality: An Overlooked Crisis
Handout #8	Contraception for Postpartum Women
Handout #9	When to Initiate Contraception for Breastfeeding and Non-Breastfeeding Women
Handout #10	Long-acting and Permanent Methods
Handout #11	Lactational Amenorrhea Method
Handout #12	GATHER adapted for HTSP
Handout #13	What Makes FP Counseling Effective?
Handout #14	FP Counseling Strategies for Different Clients
Handout #15	Provider Comfort When Counseling Men

**HANDOUT #1: ACCESS-FP PROGRAMMATIC FRAMEWORK: POSTPARTUM FAMILY PLANNING IN AN INTEGRATED CONTEXT**



**ACCESS-FP PROGRAMMATIC FRAMEWORK:  
Postpartum Family Planning in an Integrated Context**

**ACCESS-FP Programmatic Framework:**

The ACCESS-FP Programmatic Framework illustrates the relationships between postpartum family planning, maternal health, newborn health and prevention of mother-to-child transmission through the first year postpartum.

The framework illustrates the relationships as they commonly exist in programs. Dotted lines indicate those services are more theoretical than actual.

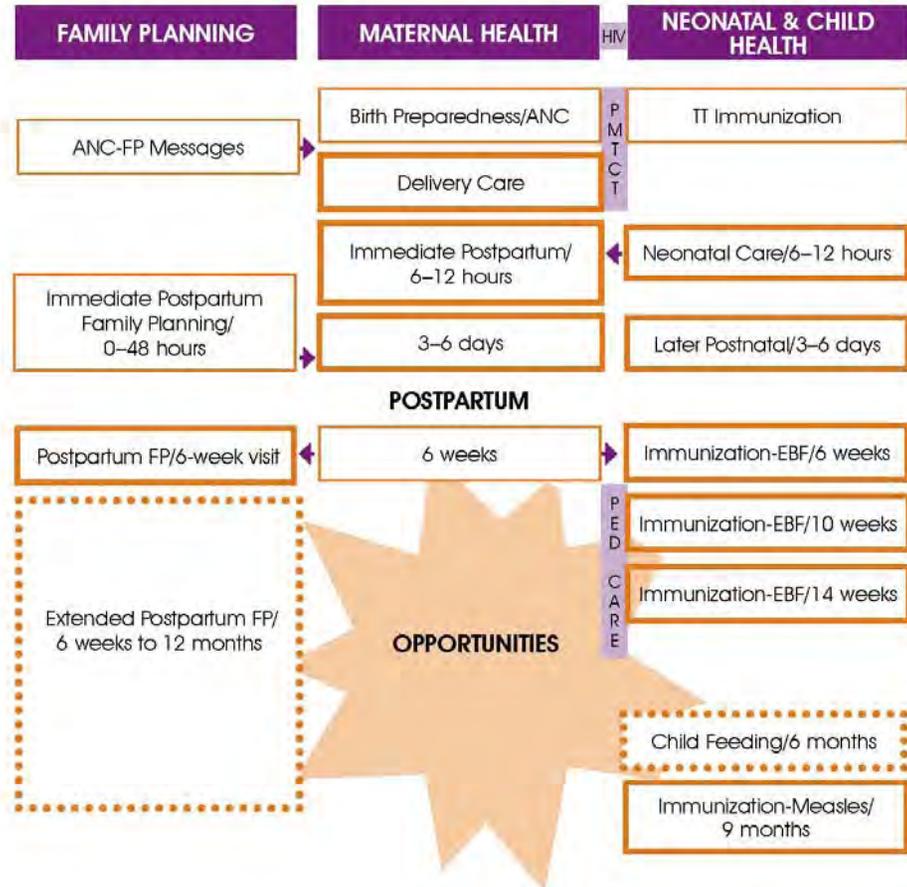
In family planning, emphasis is placed on integrating family messages in antenatal care, then immediate postpartum family planning for long-acting and permanent methods as available, with the greatest emphasis on the six-week postpartum visit.

In maternal health, more emphasis is placed on skilled delivery care and the immediate postpartum period with some reference to the six-week postpartum check.

In neonatal and infant health, emphasis is placed on immediate and later postnatal care as well as the immunization schedule.

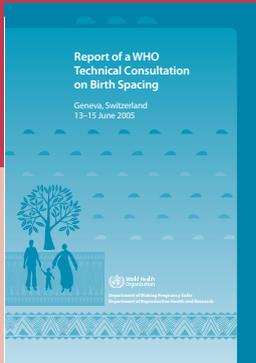
For women infected with HIV, there are special needs for counseling on exclusive breastfeeding and the effect of abrupt weaning on a woman's return to fertility.

The framework demonstrates the multiple opportunities to promote pregnancy spacing and to provide family planning information and services in the context of maternal and infant health services. These opportunities include antenatal care, early and extended postpartum visits, as well as immunization services and well child care.



Department of Reproductive  
Health and Research

Department of Making  
Pregnancy Safer



Policy brief  
Policy brief

## Birth spacing – report from a WHO technical consultation<sup>1</sup>

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

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

### Method of review and findings of the consultation

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

WHO sent the six draft papers to a selected group of experts, and received a total of 30 reviews. The reviewers' comments were compiled and circulated to all meeting par-

ticipants. At the meeting, the authors of the background papers presented their findings, and selected discussants presented the consolidated set of reviewers' comments, including their own observations. Together, the draft papers and the various commentaries constituted the basis for the consultation's deliberations.

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

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

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



World Health  
Organization

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

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

### Conclusions and recommendations

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

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

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

#### *Recommendation for spacing after a live birth*

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

#### *Recommendation for spacing after an abortion*

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

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

### Suggestions for future research

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

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

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

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

## Papers reviewed at the meeting

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

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

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

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

This paper has now been published as follows:

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

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

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

5. Rutstein SO (draft, no date). Effects of preceding birth intervals on neonatal, infant and under-five years mortality and nutritional status in developing countries: evidence from the Demographic and Health Surveys.

This paper has now been published as follows:

Rutstein SO. Effects of preceding birth intervals on neonatal, infant and under-five years mortality and nutritional status in developing countries: evidence from the Demographic and Health Surveys. *International Journal of Gynaecology and Obstetrics*, 2005, 89:S7–S24 (supplement).

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

### Supplementary paper

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

This paper has now been published as follows:

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

### For more information contact:

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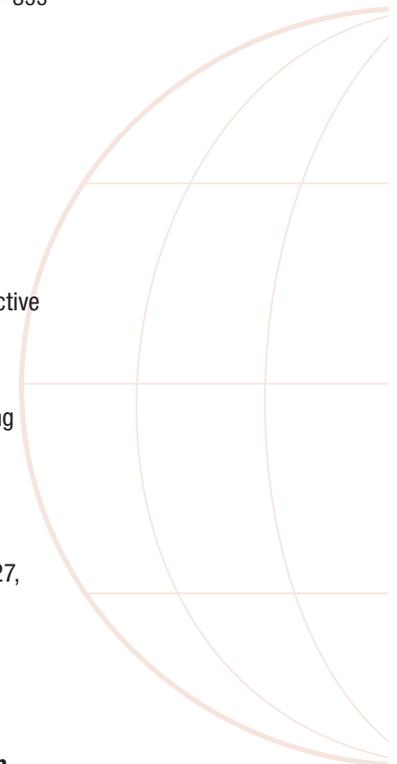
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[www.who.int/making\\_pregnancy\\_safer](http://www.who.int/making_pregnancy_safer)

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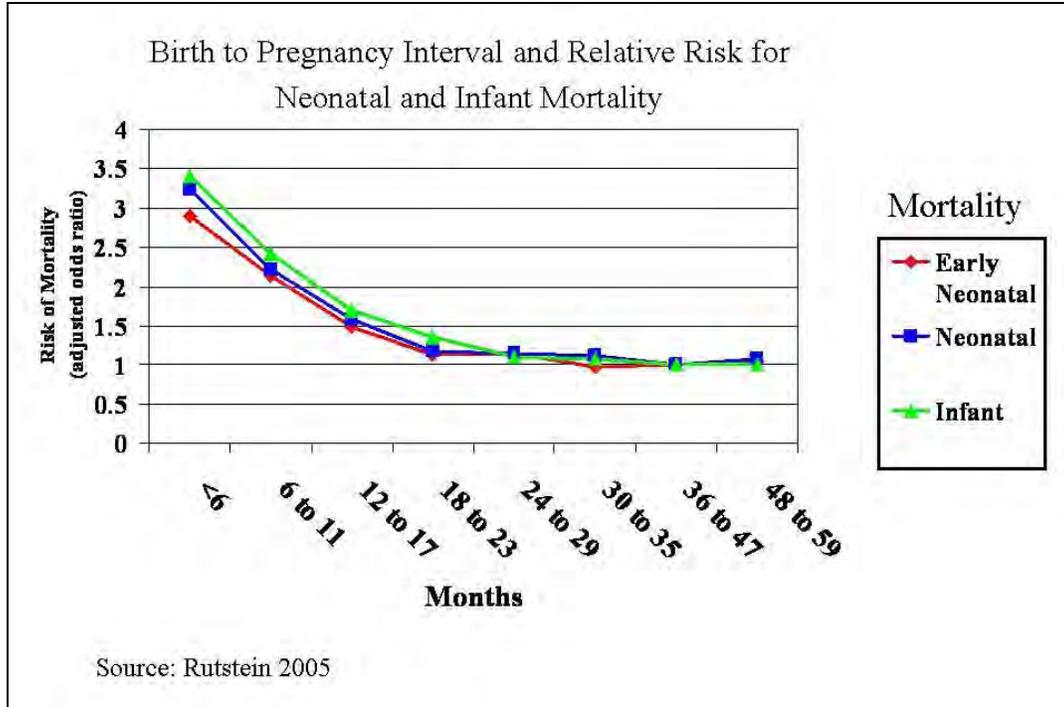


**HANDOUT #3: THE HTSP MESSAGES**

<p><b>For couples who desire a next pregnancy after a live birth</b></p> <p>For the health of the mother and the baby, wait at least 24 months, but not more than 5 years, before trying to become pregnant again.</p> <p>Consider using a family planning method of your choice during that time.</p>	<p><b>For couples who decide to have a child after a miscarriage or abortion</b></p> <p>For the health of the mother and the baby, wait at least six months before trying to become pregnant again.</p> <p>Consider using a family planning method of your choice during that time.</p>	<p><b>For adolescents</b></p> <p>For your health and your baby's health, wait until you are at least 18 years of age, before trying to become pregnant.</p> <p>If you are sexually active, consider using a family planning method of your choice until you are 18 years old.</p>
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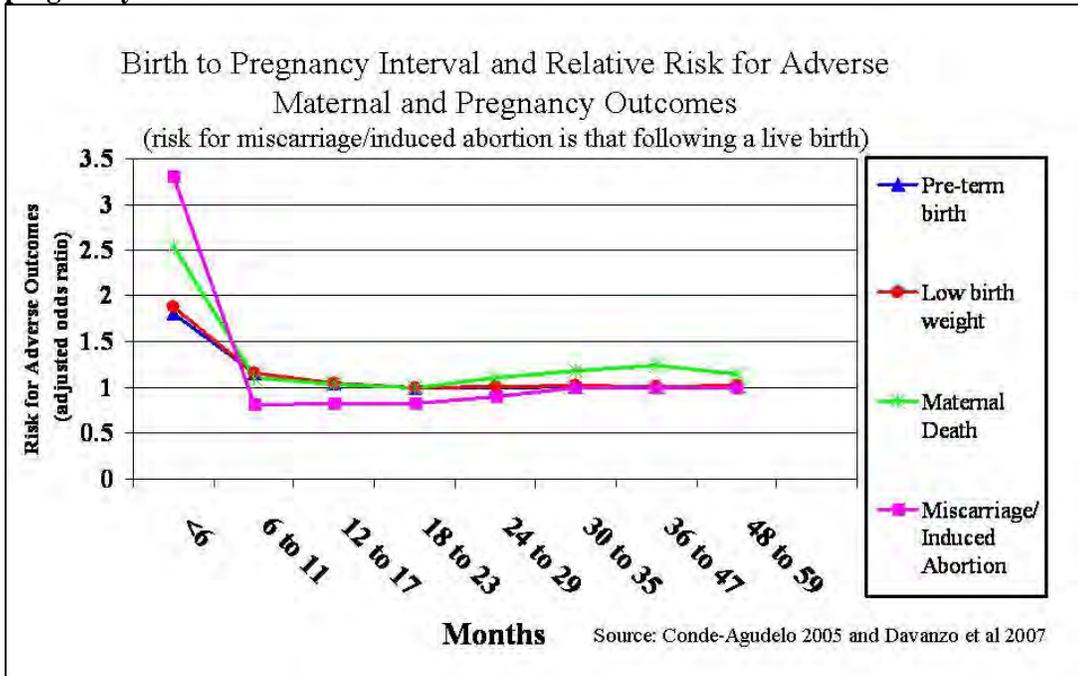
## HANDOUT #4: THE HTSP GRAPHS

**Figure 1: Improved pregnancy spacing is associated with reduced risk of neonatal and infant death.**



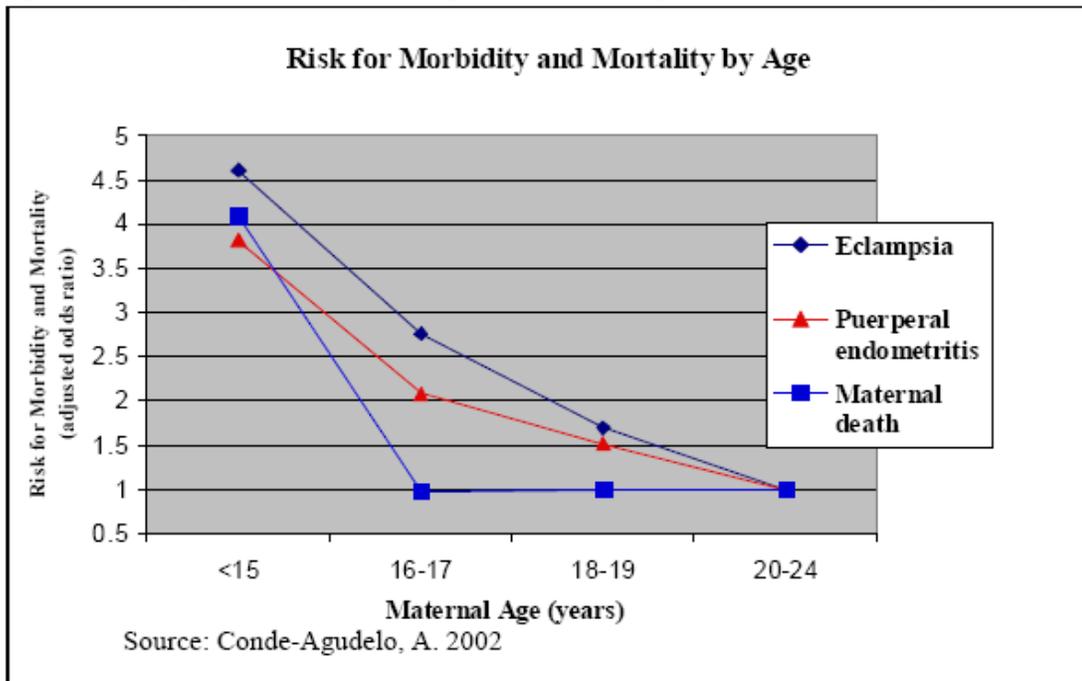
- A 24-month, birth-to-pregnancy interval is associated with reduced risks of newborn and infant mortality, based on data from developing countries in Africa, Asia, Latin America, and the Middle East.

**Figure 2: Improved pregnancy spacing is associated with reduced risk of adverse maternal and pregnancy outcomes.**



- A 24-month, birth-to-pregnancy interval is associated with reduced risks of multiple adverse health outcomes for mothers, newborns, and infants. The risk of adverse outcomes is highest with a pregnancy interval of less than six months.

**Figure 3: Young Women Under the Age of 20 Are at Higher Risk for Morbidity and Mortality\***



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

- This graph shows that women under the age of 20 are at higher risk for maternal morbidities (eclampsia and puerperal endometritis). The risks of maternal morbidity and mortality are highest when the woman is less than 15 years of age.



## HTSP 101: Everything You Want to Know About Healthy Timing and Spacing of Pregnancy

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

### Background

Over the past few years, the United States Agency for International Development (USAID) has sponsored a series of studies on pregnancy spacing and health outcomes. The research objective was to assess, from the best available evidence, the effects of pregnancy spacing on maternal, newborn and child health outcomes. In June 2005, the World Health Organization (WHO) convened a panel of 30 technical experts to review six USAID-sponsored studies. Based on their review of the evidence, the technical experts made two recommendations\* to the WHO, which are included in a report and policy brief<sup>1</sup>:

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

### What is HTSP?

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

\*WHO is reviewing the technical experts' recommendations and has requested additional analyses to address questions that arose at the 2005 meeting. WHO recommendations will be issued when their review has been completed.

Qualitative studies conducted by USAID in Pakistan, India, Bolivia, and Peru showed that women and couples are interested in the healthiest time to *become pregnant* versus when to *give birth*. In this way, HTSP differs from previous birth spacing approaches that refer only to the interval after a live birth and when to give birth. HTSP also provides guidance on the healthiest age for the first pregnancy.

Thus, HTSP encompasses a broader concept of the reproductive cycle — starting from healthiest age for the first pregnancy in adolescents, to spacing subsequent pregnancies following a live birth, still birth, miscarriage or abortion — capturing *all* pregnancy-related intervals in a woman's reproductive life.



Volunteer health worker reading an HTSP Pocket Guide in Dadaab refugee camp in Kenya (Photo credit: Jennifer Mason)

## Why HTSP? The Rationale

**Multiple studies have shown that adverse maternal and perinatal outcomes are related to closely spaced pregnancies.** As shown in Table 1, the risks are particularly high for women who become pregnant very soon after a previous pregnancy, miscarriage, or abortion.

**Table 1.** Risks of Adverse Health Outcomes After Very Short Interval Pregnancy, Compared to the Reference Group Interval Used in the Selected Study

INCREASED RISKS WHEN PREGNANCY OCCURS 6 MONTHS AFTER A LIVE BIRTH		
Adverse Outcome	Increased Risk	
Induced Abortion	650%	
Miscarriage	230%	
Newborn Death (<9 mos.)	170%	
Maternal Death	150%	
Preterm Birth	70%	
Stillborn	60%	
Low Birth Weight	60%	
INCREASED RISKS WHEN PREGNANCY OCCURS <6 MONTHS AFTER AN ABORTION OR MISCARRIAGE		
	Increased Risk with 1-2 Month Interval	With 3-5 Month Interval
Low Birth Weight	170%	140%
Maternal Anemia	160%	120%
Preterm Birth	80%	40%
Sources: Conde-Agudelo, et al, 2000, 2005, 2006; Da Vanzo, et al, 2004; Razzaque, et al, 2005; Rutstein, 2005.		

Too long intervals (>5 years) are also associated with adverse health outcomes. Thus, through the promotion of healthy timing and spacing of pregnancy, there is the potential to significantly reduce risks to both mothers and children. HTSP offers:

- **Reduced risks after a live birth:** Short birth to pregnancy intervals less than 18 months and longer than 59 months, had a greater risk for adverse perinatal outcomes, than women delivering 18 to 23 months after a live birth.<sup>2</sup>
- **Reduced risks after a miscarriage or post abortion:** Women delivering singleton infants after becoming pregnant less than six months after a previous abortion or miscarriage had a greater risk for adverse maternal and perinatal outcomes, than women delivering 18 to 23 months after a previous abortion.<sup>3</sup>

**Reduced risks for adolescents:** The annual global burden of disease report estimates that 14 million adolescent pregnancies happen every year. Sixty percent of married adolescents reported that their first birth was either mistimed or unintended.<sup>4</sup> Compared to older women, girls in their teens are twice as likely to die from pregnancy and child birth-related causes; and their babies also face a 50 percent higher risk of dying before age 1, than babies born to women in their twenties.<sup>5</sup>

**Considerable unmet need and demand for spacing still exist** in the younger 15-29 age cohorts as well as in postpartum women, as shown in the findings below.

- **Women in younger age cohorts:** Spacing is the main reason for family planning demand among women in younger age groups (15-29). Among married women 29 years or younger who wanted family planning, FP demand for spacing ranged from 66% to over 90%.<sup>6</sup> Data from developing countries also show that younger, lower parity women have the highest demand and need for spacing births. Commonly, between 90% and 100% of the demand for spacing in the 15 to 24 year age cohort, is made up of women with parity of two or less.<sup>7</sup>
- **Postpartum women:** Unmet need for spacing among postpartum women is very high. 95-98% of postpartum women do not want another child within two years – yet only 40% are using family planning.<sup>8</sup> In short, 60% of postpartum women who want to space their pregnancy have an unmet need.

**HTSP is an aspect of FP which is associated with healthy fertility and helping women and families make informed decisions about pregnancy spacing and timing to achieve healthy pregnancy outcomes.** Family planning (FP) has made great progress in helping women avoid unintended pregnancies. To date, the focus of FP has mostly been on lowered fertility, rather than healthy fertility. Findings from the WHO technical panel support the role of family planning in achieving healthy fertility and healthy pregnancy outcomes.

***HTSP is an effective entry point to strengthen and revitalize FP in sensitive settings*** because it focuses on the mother/child dyad and improved health outcomes for mother and baby. HTSP provides an opportunity to highlight family planning as a preventive intervention using the framework of healthy mothers, healthy babies, healthy families and healthy communities.

### **From Research to the Field**

The Extending Service Delivery (ESD) project, in collaboration with USAID, is currently spearheading an activity to take the evidence from research to the field.

Specifically, ESD is developing a program approach focusing on achieving three HTSP outcomes – (1) healthy pregnancy spacing after a live birth; (2) healthy pregnancy spacing after a miscarriage or induced abortion; and (3) healthy timing of the first pregnancy in adolescents, to delay until age 18, for healthy mother and healthy baby.

The first two HTSP outcomes are based on the two recommendations to WHO from the panel of technical experts. The third outcome was added by USAID to address issues of pregnancy at too early an age – a significant contributor to maternal and infant mortality in many developing countries.

### **Towards Achieving HTSP Outcomes: The Messages**

To achieve HTSP outcomes, three take-home messages have been developed – all to be discussed *in a framework of informed family planning choice, personal reproductive health goals and fertility intention.*

*For couples who desire a next pregnancy after a live birth, the messages are:*

- For the health of the mother and the baby,<sup>\*</sup> wait at least 24 months, but not more than 5 years,<sup>†</sup> before trying to become pregnant again.

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<sup>\*</sup>This message encompasses perinatal, neonatal, and infant health and can be adapted to the context – for example postpartum programs would emphasize perinatal, neonatal and maternal health.

<sup>†</sup>Some technical experts at the 2005 WHO technical consultation felt it was important to note that in birth-to pregnancy intervals of five years or more, there is evidence of increased risk of adverse maternal outcome,

- Consider using a family planning method of your choice without interruption during that time.

*For couples who decide to have a child after a miscarriage or abortion, the messages are:*

- For the health of the mother and the baby, wait at least six months before trying to become pregnant again.
- Consider using a family planning method of your choice without interruption during that time.

*For adolescents, the messages are:*

- For your health and your baby's health, wait until you are at least 18 years of age, before trying to become pregnant.
- Consider using a family planning method of your choice without interruption until you are 18 years old.

### **The Interventions**

Key HTSP interventions include:

- Advocacy at the policy level;
- Education and counseling of women and families, and linkage to FP services at the service delivery level; and
- Monitoring and evaluation.

#### ***Advocacy.***

There is significant increased risk for multiple adverse outcomes after short pregnancy intervals. Decision makers must be reached with advocacy and information about HTSP evidence and recommendations from the 2005 WHO technical consultation; DHS data on country-level burden of disease; and HTSP's important role in contributing towards maternal, neonatal and child mortality by reducing adverse maternal and perinatal risks. Country-specific advocacy briefs, developed by ESD, are available at [www.esdproj.org](http://www.esdproj.org).

#### ***Education and counseling of women and families, and linkage to FP services.***

Recent OR studies indicate that educating and counseling women and families on HTSP is

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namely pre-eclampsia, and adverse perinatal outcomes, namely pre-term birth, low birth weight and small infant size for gestational age.

associated with increased knowledge and use of FP services.<sup>9</sup> To ensure women and couples are informed, educated, and counseled about HTSP, programs need to use every window of opportunity. In addition to FP services, several other service delivery events represent excellent opportunities for HTSP education and counseling – pre-natal visits, post-partum care, well-baby check-ups, infant growth-monitoring sessions and immunization sessions as well as postabortion care services, and PMTCT/VCT/STI counseling sessions. Non-health activities such as youth, literacy, and agriculture are also good venues. Community leaders and religious leaders can also be trained as HTSP champions. Knowledge of service providers should also be increased so that FP plays a role not only in reproductive health, but also in maternal, newborn and child health. To that end, HTSP tools are available at: [www.esdproj.org](http://www.esdproj.org) to strengthen HTSP training, education and counseling activities.

Linkage to FP services is critical to achieve HTSP outcomes. Some women and couples may not want to make a decision immediately after education and counseling. Programs need to have a mechanism in place to ensure that these women return for services, have access and choice of a wide range of contraceptive methods, including long-acting and permanent methods (LAPM), or are referred for appropriate FP services including voluntary sterilization for those who wish to limit.

HTSP training materials/curricula provide information on all methods<sup>†</sup>, for both spacing and limiting, and on how to probe for fertility intentions, so that providers can refer women for voluntary sterilization if that is appropriate and requested.

**Monitoring and evaluation.** A 2004 birth spacing programmatic review<sup>10</sup> documents that most FP or maternal-child health (MCH) programs do not formally track birth to pregnancy intervals as a statistic that helps define the overall FP/MCH program success. Over the next few years, ESD will work with the HTSP Champions' Network to monitor and track changes in HTSP trends and

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<sup>†</sup>Includes information and training on all FP methods including LAPM, voluntary sterilization, probing for fertility intentions and referral to appropriate health facilities for sterilization as requested.

knowledge using a tracking matrix. ESD is also developing a list of common HTSP indicators.

## Conclusion

USAID is working in collaboration with WHO and other organizations to integrate HTSP into health and non-health programs. For countries to reduce their burden of disease and reach their Millennium Development Goals, adding HTSP interventions to their strategies and programs should be considered a priority because of significant, multiple health benefits for women and babies.

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Prepared by May Post, Extending Service Delivery Project.

Based on the ESD HTSP Strategy, available at [www.esdproj.org](http://www.esdproj.org).

Please contact [esdmail@esdproj.org](mailto:esdmail@esdproj.org) for more information.

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<sup>1</sup> Report of a WHO Technical Consultation on Birth Spacing. World Health Organization, 2006.

<sup>2</sup> Conde-Agudelo A., et al., Birth Spacing and the Risk of Adverse Perinatal Outcomes: A Meta Analysis. *Journal of the American Medical Association*, 29, April 2006.

<sup>3</sup> Conde-Agudelo A., et al., Effect of the interpregnancy interval after an abortion on maternal and perinatal health in Latin America. *International Journal of Obstetrics and Gynecology*, Vol. 89, Supplement 1, April 2005.

<sup>4</sup> Married Adolescents: No Place for Safety. WHO and UN Population Fund: WHO, 2006.

<sup>5</sup> Shane Barbara (1997), cited in *State of the World's Mothers 2006: Saving the Lives of Mothers and Newborns*. Save the Children, 2006.

<sup>6</sup> Jansen, W., Existing Demand for Birth Spacing in Developing Countries: Perspectives from Household Survey Data. *International Journal of Obstetrics and Gynecology*, Vol. 89, Supplement 1, April 2005.

<sup>7</sup> Jansen, W and L Cobb, USAID Birth Spacing Programmatic Review: An Assessment of Country-Level Programs, Communications and Training Materials. POPTECH Publication No. 2003-154-024, 2004.

<sup>8</sup> Ross and Winfrey, Contraceptive use, intention to use and unmet need during the extended postpartum period, *International Family Planning Perspectives*, Vol. 27, No. 1, March 2001.

<sup>9</sup> Minia Village Household Survey; Communications for Healthy Living, Egypt, 2000-2005; PRACHAR Project, Pathfinder/India, 2001-2005; Results of the Household Survey, TAHSEEN/Pathfinder, Egypt, 2003-2005; Promoting Postpartum Contraception: Possible Opportunities, Population Council, New Delhi 2007; Solo et al. (1999), Kenya. Cited in Report of the PAC Technical Advisory Panel, USAID, April 2007. Programs, Communications and Training Materials. POPTECH Publication No. 2003-154-024, 2004.

<sup>10</sup> Jansen, W. and L. Cobb, USAID Birth Spacing Programmatic Review: An Assessment of Country-Level.

**HANDOUT #6: BENEFITS OF HTSP VS. RISKS IF HTSP IS NOT PRACTICED**

BENEFITS OF HTSP	RISKS IF HTSP IS NOT PRACTICED
<b>For the Newborn Child</b>	
<ul style="list-style-type: none"> <li>• Newborns are more likely to be born strong and healthy.</li> <li>• Newborns may be breastfed for a longer period of time, which allows them to experience the health and nutritional benefits of breastfeeding.</li> <li>• Mother-baby bonding is enhanced by breastfeeding, which facilitates the child’s overall development</li> <li>• Mothers who are not caring for another young child under the age of three may be better able to meet the needs of their newborns.</li> </ul>	<ul style="list-style-type: none"> <li>• Risk of newborn and infant mortality is higher.</li> <li>• There may be a greater chance of a pre-term low-birth-weight baby, or the baby may be born too small for its gestational age.</li> <li>• When breastfeeding stops before six months, the newborn does not experience the health and nutritional benefits of breast milk, and the mother-baby bond may be diminished, which may affect the baby’s development.</li> </ul>
<b>For the Mother</b>	
<ul style="list-style-type: none"> <li>• The mother has a reduced risk of complications which are associated with closely spaced pregnancies.</li> <li>• She may have more time to take care of the baby if she does not have to deal with the demands of a new pregnancy.</li> <li>• She may breastfeed longer; longer duration of breastfeeding is linked to a reduced risk of breast and ovarian cancer.</li> <li>• She may be more rested and well-nourished so as to support the next healthy pregnancy.</li> <li>• She may have more time for herself, her children, and her partner, and to participate in educational, economic and social activities</li> <li>• She may have more time to prepare physically, emotionally, and financially for her next pregnancy.</li> </ul>	<ul style="list-style-type: none"> <li>• Women who experience closely spaced pregnancies are:               <ul style="list-style-type: none"> <li>○ at increased risk of miscarriage;</li> <li>○ more likely to induce an abortion; and</li> <li>○ at greater risk of maternal death.</li> </ul> </li> </ul>
<b>For Men</b>	
<ul style="list-style-type: none"> <li>• His partner may find more time to be with him, which may contribute to a better relationship.</li> <li>• Expenses associated with a new pregnancy will not be added to the expenses of the last-born child.</li> <li>• More time between births may allow a man time to plan financially and emotionally before the birth of the next child, if the couple plans to have one.</li> <li>• Men may feel an increased sense of satisfaction from:               <ul style="list-style-type: none"> <li>○ Safeguarding the health and well-being of his partner and children; and</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• The stress from closely spaced pregnancies may prevent couples from having a fulfilling relationship.</li> <li>• If the mother is too tired from a new pregnancy and raising an infant, she may not have the time or energy to spend with her partner.</li> </ul>

BENEFITS OF HTSP	RISKS IF HTSP IS NOT PRACTICED
<ul style="list-style-type: none"> <li>○ Supporting his partner in making healthy decisions regarding FP and HTSP.</li> </ul>	
<b>For the Family</b>	
<ul style="list-style-type: none"> <li>• Families can devote more resources to providing their children with food, clothing, housing, and education.</li> </ul>	<ul style="list-style-type: none"> <li>• A new pregnancy requires money for antenatal care, better nourishment for the mother, savings for the delivery costs and costs associated with the needs of a new baby.</li> <li>• Illness or a need for emergency care is more likely if the woman has closely spaced pregnancies</li> <li>• Unanticipated expenses may lead to difficult financial circumstances or poverty.</li> </ul>
<b>For the Community</b>	
<ul style="list-style-type: none"> <li>• HTSP is associated with reduced risk of death and illnesses among mothers, newborns, infants, and children, which can contribute to reductions in poverty and improvements in the quality of life for the community.</li> <li>• It may relieve the economic, social and environmental pressures from rapidly growing populations.</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of HTSP may result in a poorer quality of life for community residents, including increased medical expenses.</li> <li>• Economic growth may be slower, making it more difficult to achieve improvements in education, environmental quality, and health.</li> </ul>



# Adolescent Maternal Mortality: An Overlooked Crisis

## The Facts

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

### Contraceptive Use and Pregnancy among Adolescents

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

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

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

### Why Girls Are More Vulnerable than Older Women

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

## Family Planning Can Reduce Adolescent Maternal Mortality

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

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

## Programs and Initiatives

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

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## HANDOUT #8: CONTRACEPTION FOR POSTPARTUM WOMEN

FP METHOD	BENEFITS	LIMITATIONS
<p><b>Lactational Amenorrhea Method (LAM)</b>            LAM provides protection from pregnancy for up to six months.</p> <p>LAM is only effective if the woman is only breastfeeding, her menstruation has not returned and the baby is less than six months old. Once one of these criteria changes, she should adopt another method.</p> <p>Two out of 100 women using LAM alone in the first six months after childbirth will become pregnant.</p> <p>(LAM is described further below.)</p>	<ul style="list-style-type: none"> <li>- No side effects or health risks.</li> <li>- Encourages breastfeeding which provides health benefits to the baby.</li> <li>- No cost</li> <li>- Can be used by all women.</li> </ul>	<ul style="list-style-type: none"> <li>- Must be only breastfeeding, which may be difficult for some women to practice</li> <li>- Is not effective once a woman is not only breastfeeding (mixed feeding), her menstruation returns or the baby is more than six months old.</li> <li>- Does not protect against STIs and HIV.</li> </ul>
<p><b>Condoms</b>            Male condoms are readily available and inexpensive</p> <p>Female condoms are becoming increasingly available.</p> <p>Both types of condoms provide protection against pregnancy and STIs.</p> <p>15 out of 100 women using male condoms alone will become pregnant, while 21 of 100 women using female condoms alone will become pregnant.</p>	<p>For male condoms:</p> <ul style="list-style-type: none"> <li>- Effective immediately.</li> <li>- Does not interfere with breastfeeding.</li> <li>- Can be used as a backup for other methods.</li> <li>- No health risks or side effects.</li> <li>- Do not require clinical assessment or prescription.</li> </ul> <p>For female condoms:</p> <ul style="list-style-type: none"> <li>- Female controlled method.</li> <li>- Does not interfere with intercourse, as it may be inserted up to eight hours before sex.</li> </ul>	<p>For male condoms:</p> <ul style="list-style-type: none"> <li>- Effectiveness depends on the user. Condoms are most effective when they are used consistently and correctly.</li> <li>- Some do not like how condoms feel.</li> <li>- Women may find it difficult to discuss condom use with their partners.</li> <li>- Persistent rumors and misinformation about condoms.</li> <li>- A new condom must be used with each act of intercourse.</li> </ul> <p>For female condoms:</p> <ul style="list-style-type: none"> <li>- More limited access and can be expensive.</li> <li>- Effectiveness depends on willingness to follow instructions.</li> <li>- Supply and resupply may not be readily available.</li> <li>- A new condom must be used with each act of intercourse.</li> </ul>

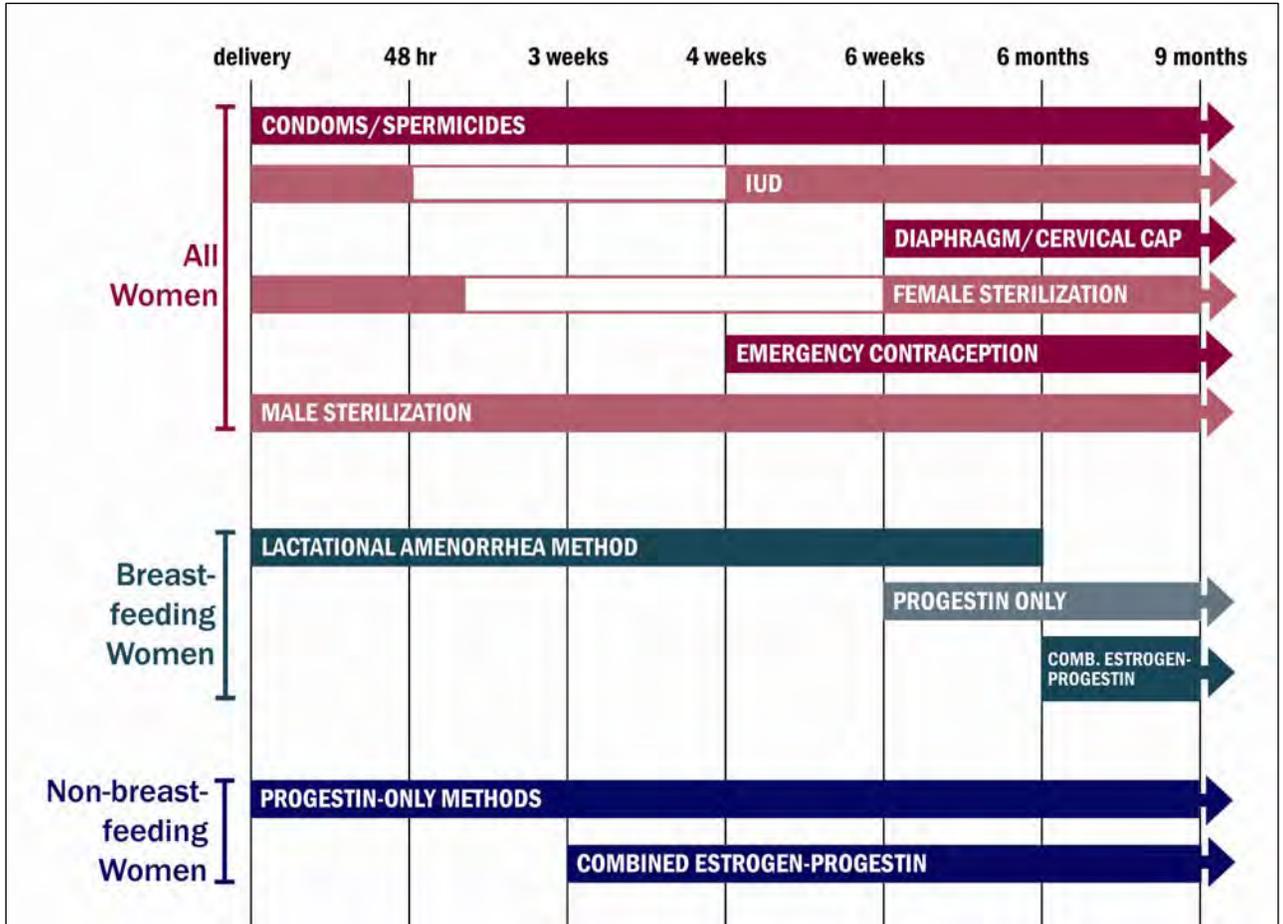
FP METHOD	BENEFITS	LIMITATIONS
<p><b>Progestin Only Pills (POPs)</b>  POPs (also known as the “mini-pill”) contain a low dose of progestin, which is similar to the hormone progesterone. POPs are appropriate for breastfeeding women, because they do not interfere with breast milk production. Breastfeeding enhances the effectiveness of POPs. Among breastfeeding women, only one (1) woman out of 100 will become pregnant.</p> <p>Among non-breastfeeding women, three to ten (3 to 10) women out of 100 will become pregnant.</p>	<ul style="list-style-type: none"> <li>- Safe for nearly all women, especially breastfeeding women</li> <li>- Highly effective, reversible, easy to use.</li> <li>- Effective within first cycle.</li> <li>- Can be provided by trained non-medical staff.</li> </ul>	<ul style="list-style-type: none"> <li>- Must be taken every day.</li> <li>- Requires regular/ dependable supply.</li> <li>- May cause side effects in some women</li> <li>- Do not protect against STIs and HIV.</li> </ul>
<p><b>Combined Oral Contraceptives (COCs)</b>  COCs contain low doses of progestin and estrogen. They are safe for nearly all women to use.</p> <p>Postpartum women who are breastfeeding should not use COCs for the first six months, because the hormones interfere with breast milk production.</p> <p>Postpartum women who are not breastfeeding can initiate use of COCs three weeks after childbirth.</p> <p>Postpartum women who are breastfeeding can start COCs when her menses return, or she is no longer fully breastfeeding or at six months Postpartum, whichever comes first.</p> <p>Approximately eight (8) out of 100 women will become pregnant using COCs.</p>	<ul style="list-style-type: none"> <li>- Safe for nearly all women, except breastfeeding women in the first six months Postpartum.</li> <li>- Highly effective, reversible, easy to use.</li> <li>- Can be provided by trained non-medical staff</li> </ul>	<ul style="list-style-type: none"> <li>- Must be taken every day.</li> <li>- Requires regular/ dependable supply.</li> <li>- May cause side effects in some women</li> <li>- Side effects such as changes in bleeding patterns must be addressed to ensure the client continues with COCs.</li> <li>- Do not protect against STIs and HIV</li> <li>- Breastfeeding women should not use COCs in the first six months Postpartum, as COCs decrease milk production.</li> </ul>
<p><b>Progestin-only Injectables</b>  Progestin-only injectables are appropriate for most breastfeeding women. This is a very effective method and it does not interfere with breast milk production. About three (3) women out of 100 will become pregnant using injectables.</p>	<ul style="list-style-type: none"> <li>- Very effective, reversible and few side effects, such as changes in menstrual bleeding (e.g., spotting initially and then no menses). Some also experience weight gain</li> <li>- No effect on breast milk production</li> <li>- Does not interfere with sexual intercourse.</li> <li>- No need for daily pill-taking.</li> <li>- Effective within 24 hours.</li> </ul>	<ul style="list-style-type: none"> <li>- May produce minor side effects in some women.</li> <li>- Most women experience a delayed return to fertility (for half of the users, it takes 6 to 9 months after discontinuation to get pregnant).</li> <li>- Requires regular injections. One type is administered every two months, while the other is administered every three months.</li> <li>- Do not protect against STIs and HIV.</li> </ul>

FP METHOD	BENEFITS	LIMITATIONS
<p><b>Intrauterine Contraceptive Device (IUCD)</b> The copper-bearing IUCD is appropriate for breastfeeding women. The IUCD can be inserted within the first 48 hours postpartum, or between four weeks and six months postpartum, as long as the woman has no contra-indications and it is reasonably certain that she is not pregnant.</p> <p>IUCDs are a highly effective, long-term method. Less than one (1) woman out of 100 women using IUCDs will become pregnant.</p>	<ul style="list-style-type: none"> <li>- Immediately effective upon insertion.</li> <li>- Does not interfere with sexual intercourse.</li> <li>- Immediately reversible with no delay in return to fertility.</li> <li>- Does not interfere with breastfeeding.</li> <li>- No interactions with any medicines.</li> <li>- No hormonal side effects</li> <li>- No need for follow up unless there are problems.</li> <li>- No need to purchase any supplies.</li> </ul>	<ul style="list-style-type: none"> <li>- Possibility of longer and heavier menstrual periods; bleeding or spotting between periods; more cramps or pain during periods.</li> <li>- Does not protect against STIs and HIV.</li> <li>- Requires a trained health care provider to insert and remove the IUCD.</li> </ul>
<p><b>Implants</b> Implants that contain progestin can be used by breastfeeding women. Implants are small plastic rods that are inserted under the skin of a woman's upper arm.</p> <p>If the woman is breastfeeding, implants can be used at around six weeks postpartum</p> <p>Implants are a very effective, long-term method that last for 3 – 5 years. Less than one (1) woman out of 100 using implants will become pregnant</p>	<ul style="list-style-type: none"> <li>- Very effective.</li> <li>- Immediate return to fertility once implants are removed.</li> <li>- Does not interfere with breastfeeding.</li> <li>- No need for return visits or purchase of supplies.</li> </ul>	<ul style="list-style-type: none"> <li>- Possibility of changes in bleeding patterns. Some women may experience other side effects.</li> <li>- Do not protect against STIs and HIV.</li> <li>- Requires trained provider to insert and remove implants.</li> </ul>
<p><b>Voluntary Sterilization</b> Tubal Ligation (for women) and vasectomy (for men) are very effective contraceptive methods. These methods are permanent and should not be considered reversible. Written consent is required from the client.</p> <p>Less than one (1) woman out of 100 will become pregnant after either male or female sterilization.</p>	<p>For women:</p> <ul style="list-style-type: none"> <li>- Simple surgery using local anesthesia.</li> <li>- Nothing to remember, no supplies, no repeat visits.</li> <li>- No effect on breast milk production.</li> <li>- No known long-term side effects or health risks.</li> <li>- Can be performed any time when it is reasonably sure that the woman is not pregnant.</li> </ul> <p>For men:</p> <ul style="list-style-type: none"> <li>- Simple surgery performed using local anesthesia.</li> <li>- Nothing to remember, except condoms for the first 3 months.</li> <li>- No known long-term side effects.</li> <li>- Easier than tubal ligation.</li> <li>- No change in sexual function.</li> </ul>	<p>For women:</p> <ul style="list-style-type: none"> <li>- Uncommon complications of surgery include: <ul style="list-style-type: none"> <li>• Infection</li> <li>• Bleeding at the incision</li> <li>• Injury</li> </ul> </li> <li>- Requires a trained provider.</li> <li>- Must be considered permanent.</li> <li>- Does not protect against STIs and HIV.</li> </ul> <p>For men:</p> <ul style="list-style-type: none"> <li>- Short-term discomfort/pain following procedure.</li> <li>- Must be considered permanent.</li> <li>- Delayed effectiveness (requires at least 3 months or more than 20 ejaculations for procedure to be effective).</li> <li>- Requires a trained provider.</li> <li>- Does not protect against STIs and HIV.</li> </ul>

***Of special note: Women who have HIV can start and continue to use most contraceptives safely, with some limitations, including LAM. In general, contraceptives and anti-retroviral medications do not interfere with each other.***

**HANDOUT #9: WHEN TO INITIATE CONTRACEPTION FOR BREASTFEEDING AND NON-BREASTFEEDING WOMEN**

**FP for Postpartum Women**



## The Benefits of Long-Acting and Permanent Methods for Individuals

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

### Addressing diverse needs

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

At least 15 percent of all couples worldwide choose a method of family planning that men actively participate in using, such as condoms, withdrawal, periodic abstinence, or vasectomy.<sup>2</sup>

**For men who have achieved their desired family size, vasectomy is the only method that offers highly effective, permanent protection from unintended pregnancies.** The procedure is simpler and safer than female sterilization. It generally takes 15 minutes or less when performed by a trained surgeon, is almost painless, and is usually not complicated.<sup>3</sup>

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

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

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### Reversible LAPMs are an alternative for women who discontinue

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

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

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

## Offering unique advantages

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

**Table 1. Pregnancy Rates During One Year of Typical Use**

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

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

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

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

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

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

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

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

### Benefiting family health and well-being

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

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

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

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

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

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

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

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

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

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

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

9 WHO.

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

11 ESD Project.



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

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

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

**Lactational** = related to **breastfeeding**

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

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

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

- 1) breastfeeding only<sup>1</sup>;
- 2) no return of menses<sup>2</sup>; and
- 3) baby less than six months old.

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

#### Key Elements of LAM Services

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

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

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<sup>1</sup> "Breastfeeding only" means that no other liquid or solid except medicine, vitamins, and vaccines are given to the infant. "Breastfeeding only" is closest to the definition of "fully" breastfeeding. "Nearly fully" breastfeeding means that the vast majority of feeds given to the infant are breastfeeds. The exact definition of "vast majority" has been specified in a variety of ways.

<sup>2</sup> "Menses" is described as any bleeding after the first two months postpartum

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

<b>ELEMENT</b>	<b>CONTENT DESCRIPTION</b>
<b>LAM criteria</b>	<ul style="list-style-type: none"> <li>▪ The three criteria for LAM use and what each means to ensuring contraceptive protection.</li> <li>▪ All three criteria must be met.</li> </ul>
<b>Breastfeeding support</b>	<ul style="list-style-type: none"> <li>▪ The optimal breastfeeding behaviors that help maximize the contraceptive effect of LAM (textbox below).</li> <li>▪ When to contact a provider for support or management of breastfeeding difficulties.</li> </ul>
<b>Return to fertility</b>	<ul style="list-style-type: none"> <li>▪ Chances of becoming pregnant during the postpartum period change according to breastfeeding status, intensity of breastfeeding and length of time postpartum.</li> <li>▪ If any one of the three criteria for LAM use is not met, pregnancy can occur even without the return of menses.</li> </ul>
<b>Reproductive goals/ Fertility intentions</b>	<ul style="list-style-type: none"> <li>▪ The woman's or couple's desire for more children and for spacing or limiting births.</li> </ul>
<b>Healthy timing and spacing of pregnancies</b>	<ul style="list-style-type: none"> <li>▪ Women/couples desiring another child should wait at least two years after a live birth before trying to get pregnant again.</li> </ul>
<b>Contraceptive choices</b>	<ul style="list-style-type: none"> <li>▪ The range of available contraceptive methods to consider for use by breastfeeding women.</li> <li>▪ Which methods are appropriate, depending on the timing of their use and the woman's need for protection from sexually transmitted infections and pregnancy.</li> <li>▪ Provide contraceptive methods or referrals as indicated.</li> </ul>
<b>Transition to another modern method</b>	<ul style="list-style-type: none"> <li>▪ The conditions that indicate a need to use, or transition to, another contraceptive method.</li> </ul>

#### **OPTIMAL BREASTFEEDING BEHAVIORS**

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

**Timing and frequency of counseling for LAM:** While LAM counseling during the antenatal period is highly desirable, there is evidence that two client visits during the postpartum period can bring about good LAM acceptance and compliance on the part of postpartum women, and can help ensure the effectiveness of the method.<sup>3</sup> Program experience indicates that the correct timing of these two visits is critical: one should take place during the immediate postpartum, the other at the time of transition (i.e., when a woman no longer meets all three LAM criteria or when she wants to transition to another family planning method). The purpose of the first visit is to determine whether breastfeeding has been well established and is sufficient for LAM to be effective. The purpose of the second visit is: to facilitate the transition to another modern contraceptive method, by helping the woman choose an appropriate method based on her fertility intentions; and to discuss the importance of exclusive breastfeeding for six months, child feeding after six months and continued breastfeeding for up to two years and beyond.

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

### **Addressing Perceived Limitations**

A common rationale for not offering LAM is that it is a temporary method and represents a missed opportunity for women who might otherwise initiate another modern method in the first few months postpartum. However, 38% of women in the first 12 months postpartum who intend to use contraception are not doing so.<sup>4</sup> Moreover, a study in Jordan measured the transition rate from LAM to another modern method at one year postpartum and suggests that LAM attracts previous non-users to the modern method mix.<sup>5</sup>

Another concern is that LAM has decreased efficacy if mother and child are separated for extended periods. One study measured the efficacy of LAM among working women who were separated from their infants for about eight hours per day, but who expressed their breast milk at least every four hours. The six-month pregnancy rate among those working women who were amenorrheic, who expressed their breast milk every four hours and whose babies were under six months of age was 5.2%.<sup>6</sup> While less effective than typical or ideal LAM use (98% and 99.5%, respectively), this compares favorably to a 25-30% pregnancy rate for non-breastfeeding women not using contraception during the same period.<sup>7</sup>

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3 Peterson, A. 2000. Multicenter study of the lactational amenorrhea method (LAM) III: Effectiveness, duration, and satisfaction with reduced client-provider contact. *Contraception* 62: 221-230.

4 Ross, J. A., Winfrey, W. L. 2001. Contraceptive use, intention to use and unmet need in the postpartum period. *International Family Planning Perspectives* 27 (1): 20-28.

5 Bongiovanni, A. et al. 2005. Promoting the Lactational Amenorrhea Method (LAM) in Jordan Increases Modern Contraception Use in the Extended Postpartum Period. The LINKAGES Project, Academy for Educational Development.

6 Valdes, V. et al. 2000. The efficacy of the Lactational Amenorrhea Method (LAM) among working women. *Contraception* 62:217-219.

7 Gray, R. et al. 1987. Postpartum return of ovarian activity in nonbreastfeeding women monitored by urinary assays. *Journal of Endocrinology* 64 (4).

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

- LAM effectiveness has been proven repeatedly in prospective clinical trials over the past two decades; LAM effectiveness is 99.5% for ideal use and 98% for typical use.<sup>8</sup>
- To promote informed choice, the contraceptive method mix should include LAM. LAM is simple to use and readily accessible, but requires effective counseling.
- LAM has child survival benefits. It supports exclusive breastfeeding for the first six months, which provides nutrients and immunological protection to the infant, as well as prevents pregnancies during the critical first months postpartum.
- LAM reaches the sub-population of women who have not been using modern contraception. Evidence suggests that LAM users within this group transition to become new acceptors of other modern methods.
- In countries with high fertility and low contraceptive prevalence, including LAM in the method mix can serve as an “entry point” for stimulating the use of other modern methods.
- Infant immunization visits provide opportunities to inquire about LAM criteria and counsel on the need to transition to other methods.

### **ADVANTAGES OF USING LAM**

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

**For more information about LAM, see the ACCESS-FP Web site: [www.accesstohealth.org](http://www.accesstohealth.org)**

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

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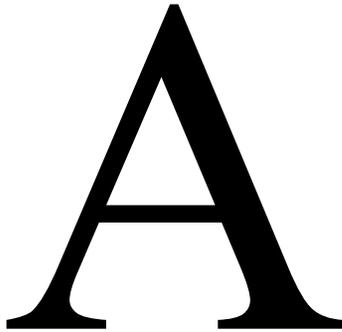
<sup>8</sup> World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs (CCP), INFO Project. *Family Planning: A Global Handbook for Providers*. Baltimore and Geneva: CCP and WHO, 2007.

**HANDOUT #12: GATHER ADAPTED FOR HTSP**

**G**

**Greet the client in a friendly way.**

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

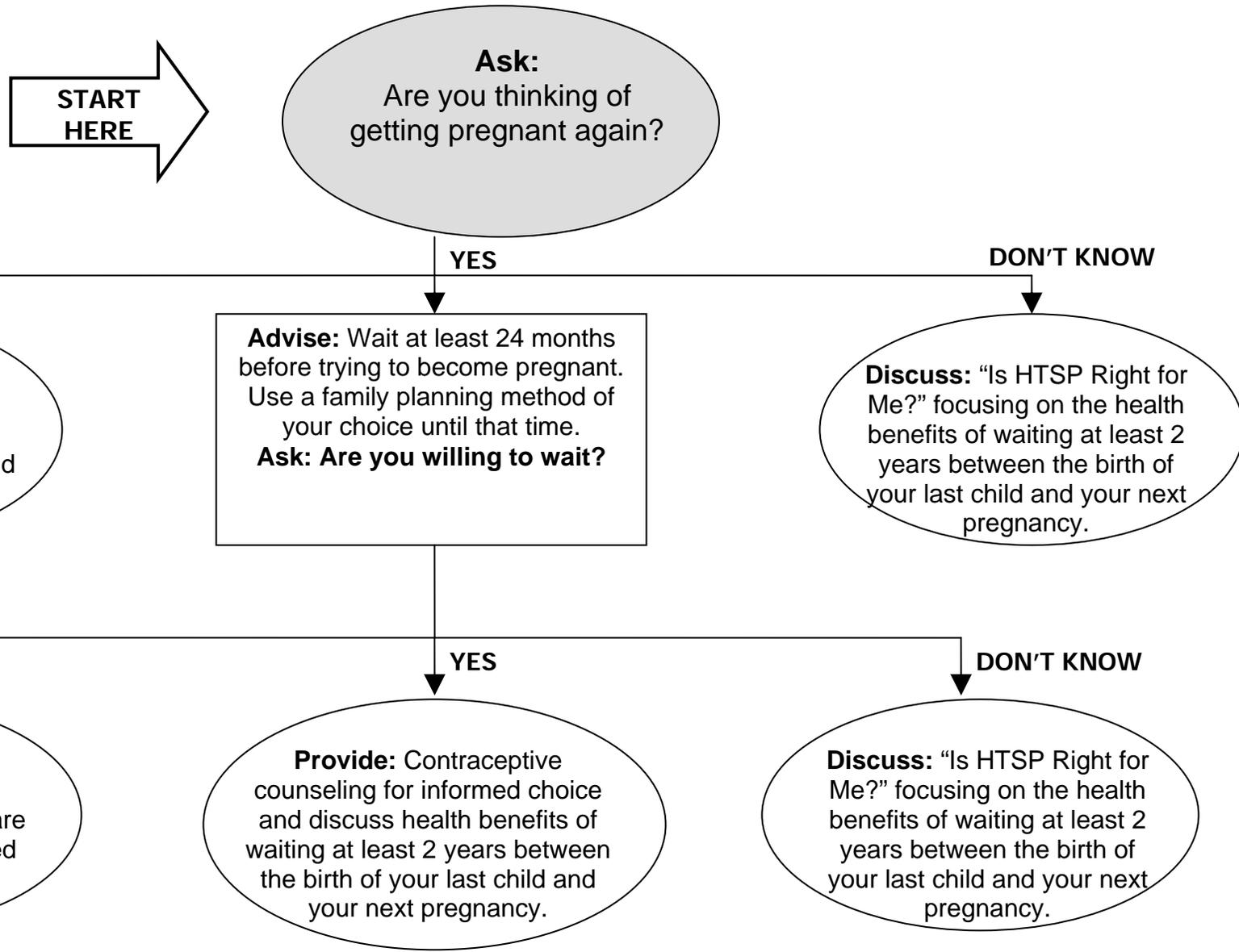


## **Ask the client why she has come in for a visit.**

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

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

## Fertility Intention Question Tree for Postpartum Women



**T**

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

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

## IS HTSP RIGHT FOR ME?

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

<b>Reasons for not waiting before youngest child is at least 2 years old:</b>	<b>Possible Responses</b>
<ul style="list-style-type: none"> <li>It is best to have the children one after the other while young so the mother is strong enough to raise them.</li> </ul>	<ul style="list-style-type: none"> <li>Even young mothers can be stressed and weakened by closely spaced pregnancies.</li> </ul>
<ul style="list-style-type: none"> <li>It is best to have children one after the other so that they can have a companion close to their age with whom they can play.</li> </ul>	<ul style="list-style-type: none"> <li>Children closely spaced together may demand more attention from the mother.</li> </ul>
<ul style="list-style-type: none"> <li>It is easier to raise two children close to each other in age, because they can share clothes, toys, and the mother's time. It also saves money.</li> </ul>	<ul style="list-style-type: none"> <li>All mothers need time to regain their energy and health after childbirth to be ready for a healthy next pregnancy.</li> </ul>
<ul style="list-style-type: none"> <li>It is more convenient to complete the family quickly and then go for permanent methods like surgical sterilization</li> </ul>	<ul style="list-style-type: none"> <li>The mother can give the last-born child all the needed attention to grow healthy, be well fed, and loved. If she is exhausted from a new pregnancy, she may not be able to give the last-born child enough attention.</li> </ul>
<ul style="list-style-type: none"> <li>If a woman waits too long, she will be too old to have another child.</li> </ul>	<ul style="list-style-type: none"> <li>It is better for the whole family if the mother and children are healthy, which may not happen if the births are closely spaced.</li> </ul>
<b>Common reasons for not practicing HTSP:</b>	<b>Possible Responses</b>
<ul style="list-style-type: none"> <li>Her religion does not allow her to use FP.</li> </ul>	<ul style="list-style-type: none"> <li>You can use fertility-based awareness methods and other natural methods to plan your family. You can also practice LAM by breastfeeding.</li> </ul>
<ul style="list-style-type: none"> <li>Her husband is not interested in discussing family planning or pregnancy spacing and/or he feels that it is her responsibility, not his.</li> </ul>	<ul style="list-style-type: none"> <li>Pregnancy spacing is a joint responsibility and there are many economic, social and emotional advantages to spacing children.</li> </ul>
<ul style="list-style-type: none"> <li>The man's virility may be questioned if his wife does not become pregnant quickly.</li> </ul>	<ul style="list-style-type: none"> <li>A responsible man knows that his family's health is important, and he is willing to take steps to ensure that his family is healthy by planning and spacing his children.</li> </ul>
<ul style="list-style-type: none"> <li>The woman's fertility may be questioned if she is not able to become pregnant quickly.</li> </ul>	<ul style="list-style-type: none"> <li>While it is important to acknowledge the concerns and expectations of her husband and family, they must also understand the risks of closely spaced pregnancies to the health of the woman, her current and future children.</li> </ul>
<b>Reasons for not waiting until age 18:</b>	<b>Possible Responses</b>

## IS HTSP RIGHT FOR ME?

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

<ul style="list-style-type: none"> <li>• It is best to have children while young so the mother is strong enough to raise them.</li> </ul>	<ul style="list-style-type: none"> <li>• Married adolescents need time to physically and psychologically mature so that they are prepared for pregnancy and childbirth. Delaying the first child until a young woman is at least 18 increases the chances of having a healthy pregnancy and a healthy child.</li> </ul>
<ul style="list-style-type: none"> <li>• It is more convenient to complete the family quickly and then go for permanent methods like surgical sterilization.</li> </ul>	<ul style="list-style-type: none"> <li>• Completing a family can be done quickly and safely after the age of 18, after which permanent methods and surgical sterilization are options.</li> </ul>
<ul style="list-style-type: none"> <li>• If a woman waits too long, she will be too old to a child.</li> </ul>	<ul style="list-style-type: none"> <li>• Waiting until you are 18 is not too long and women can have healthy children safely for many years after that.</li> </ul>
<ul style="list-style-type: none"> <li>• Members of her family, such as her husband or mother-in-law are pressuring her to have a child. The family may pressure the woman to get pregnant as soon as she marries, even if she is very young. In many cases, it is important to demonstrate her fertility and/or produce a male child as soon as possible.</li> </ul>	<ul style="list-style-type: none"> <li>• While it is important to acknowledge the concerns and expectations of her husband and family, women must also understand the risks of too early pregnancies to the health of the mother and her future children.</li> </ul>
<p><b>Reasons for not waiting after a miscarriage or abortion:</b></p>	<p><b>Possible Responses</b></p>
<ul style="list-style-type: none"> <li>• It is more convenient to complete the family quickly and then go for permanent methods like surgical sterilization.</li> </ul>	<ul style="list-style-type: none"> <li>• Waiting 6 months will not hinder your time to complete your ideal family size, after which permanent methods and surgical sterilization are options.</li> </ul>
<ul style="list-style-type: none"> <li>• Members of her family, such as her husband or mother-in-law are pressuring her to have a child. The family may pressure the woman to get pregnant as soon as possible. In many cases, it is important to demonstrate her fertility and/or produce a male child.</li> </ul>	<ul style="list-style-type: none"> <li>• While it is important to acknowledge the concerns and expectations of her husband and family, women must also understand the risks of too early pregnancies to the health of the mother and her future children.</li> </ul>

# H

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

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

# E

## **Explain how to use the method.**

- After the client has chosen a method, give her supplies, if appropriate.
- If the method cannot be given immediately, tell the client how, when, and where it will be provided. Provide a back up method, such as condoms.
- For some methods, such as voluntary surgical contraception, the client may have to sign a consent form which states that the client wants the method, has been given information about it, and understands the information (please refer to the procedures for voluntary sterilization in your country). Help the client understand the consent form.
- Ask the client to repeat the instructions on using and/or obtaining her method. Listen carefully to make sure she remembers and understands.
- Describe any possible side effects and warning signs. Clearly inform the client what to do if they occur.
- Ask the client to repeat this information and clarify as needed.
- If possible, give the client printed material about the method.
- Inform the client when to come back for a follow-up visit as needed, (e.g. for resupply, check up, etc)
- Remind the client that she should use the method for at least two years after the birth of her last child (for postpartum women); or for at least six months following a miscarriage or abortion; or until she is at least 18 years old; or permanently if she wants no more children.
- Inform the client to come back sooner if she wishes, or if side effects or warning signs occur.

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

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

## **HANDOUT #13      WHAT MAKES FP COUNSELING EFFECTIVE?**

### **What makes FP counseling effective?**

A good counselor:

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

Furthermore, a good family planning counselor:

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

A complete family planning session should cover the following:

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

Source: [www.rho.org/html/fpp\\_keyissues.html](http://www.rho.org/html/fpp_keyissues.html)

**HANDOUT #14: FAMILY PLANNING COUNSELING STRATEGIES FOR DIFFERENT CLIENTS**

<b>Client Type</b>	<b>Usual Counseling Tasks</b>
<b>Returning clients with no problems</b>	<ul style="list-style-type: none"> <li>• Provide more supplies or routine follow-up</li> <li>• Ask a friendly question about how the client is doing with the method.</li> <li>• Assess her intentions around becoming pregnant to ensure she continues to practice HTSP, where appropriate.</li> </ul>
<b>Returning clients with problems</b>	<ul style="list-style-type: none"> <li>• Understand the problem and help resolve it—whether the problem is side effects, trouble using the method, an uncooperative partner, or another problem.</li> <li>• Help her choose another method, if she so desires, so that she does not discontinue the use of her method and risk an unplanned or closely spaced pregnancy</li> <li>• Remind her of the importance of practicing HTSP.</li> </ul>
<b>New clients with a method in mind</b>	<ul style="list-style-type: none"> <li>• Check that the client's understanding of the method is accurate</li> <li>• Support the client's choice, based on your assessment of the client's situation and if the client is medically eligible</li> <li>• Discuss how to use method and how to cope with any side effects</li> <li>• Discuss the health benefits of HTSP specific to her situation (e.g. delay to age 18, spacing post partum or post abortion) and how FP can help her maintain her health and ensure healthy pregnancies.</li> </ul>
<b>New clients with no method in mind</b>	<ul style="list-style-type: none"> <li>• Discuss the client's situation, plans (such as fertility intentions, desired family size), and what is important to her about a method</li> <li>• Help the client consider methods that might suit her particular situation. If needed, help her reach a decision</li> <li>• Support the client's choice, give instructions on use, and discuss how to cope with any side effects</li> <li>• Discuss the health benefits of HTSP specific to her situation (e.g. delay to age 18, spacing post partum or post abortion) and how FP can help her maintain her health and ensure healthy pregnancies.</li> </ul>

**HANDOUT #15: PROVIDER COMFORT WHEN COUNSELING MEN**

Read each statement and then check the box that most closely matches your opinion about the statement.

<b>Statement</b>	<b>Agree</b>	<b>Disagree</b>
I feel more comfortable with the idea of providing FP counseling to postpartum women than to the husband/partner of a postpartum woman		
I believe men are not interested in discussing postpartum FP		
I believe men would rather receive information about FP from a male provider than a female provider		
I would feel comfortable listening to a male client discussing his sexual behaviors, concerns or problems related to postpartum family planning		
I would feel comfortable professionally addressing a male client's flirting with me or making sexual remarks to me		
I would feel comfortable bringing up male methods of contraception during a couples counseling session on postpartum FP		
I would feel comfortable bringing up the topic of using condoms to prevent STIs and HIV with married couples		
I would feel comfortable making sure that women assert their voices, needs and concerns during a couples counseling session on postpartum FP		
I look forward to including men in couple's counseling for postpartum FP.		