

Healthy Timing and Spacing of Pregnancy (HTSP) in Pakistan

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*

Summary

Key research findings regarding the risks of closely spaced pregnancies:

- Recent USAID-sponsored research found that unhealthy pregnancy spacing is associated with multiple adverse outcomes for mothers and newborns.
- Becoming pregnant too soon after a previous birth, miscarriage, or abortion places mothers and newborns at a higher risk of health complications—or even death.
- Early pregnancy (when mother is younger than 18) the mothers and their newborns face increased risks of health complications compared to women 20-24 years old.

In Pakistan:

- Among married women of reproductive age (MWRA) approximately 1 out of 3 of births are spaced <2 years apart
- Among mothers between 15 and 19 years old, 60% of births are spaced <2 years apart
- Birth-to-birth pregnancy intervals have become *shorter* over the last 6 years.
- The desire to space pregnancies is low (>20% among married women), but increasing.

Considerations for program design:

- When women and their families are advised of the benefits of pregnancy delay and spacing, use of family planning increases substantially.
- How can improved HTSP advocacy, behavior change communication, counseling, and community outreach play a role in helping women achieve the longer intervals they want and reduce the risk of the adverse health outcomes?

Consider these findings in relation to the overall risks to mothers and newborns in Pakistan.

Annual number of births*	4,773,000
Annual number of neonatal deaths**	272,330
Neonatal mortality rate*	57
Annual number of infant deaths (includes neonatal)**	377,440
Infant mortality rate*	79
Annual number of <5 deaths (includes both infant and neonatal deaths)*	473,000
Child mortality rate*	99
Annual number of low birth weight infants**	906,870
% of infants with low birth weight*	19
Annual number of maternal deaths**	23,865
Maternal mortality rate (UNICEF adjusted #)*	500
Lifetime risk of maternal death when a woman becomes pregnant*	1 in 31

Healthy timing and spacing of pregnancy may help reduce the consequences of these health risks for mothers and newborns.

*Source: UNICEF, 2007 State of the World's Children

Introduction

Recent research from developing countries shows that unhealthy timing or spacing of pregnancies is linked to increased risk of multiple adverse health outcomes. Table 1 shows how it can affect the health of the health of the mother and the newborn.

Following a pregnancy that occurred quickly after a previous birth, the risk of a child dying is at least twice as high as that for longer intervals.

An infant born after a short interval has increased chances of:

- Being born pre-term
- Having below normal weight at birth
- Being small for gestational age

A woman who becomes pregnant too quickly following a previous birth, or induced abortion or miscarriage, faces higher risks of:

- Anemia
- Premature rupture of membranes
- Abortion
- Miscarriage
- Death

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

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%	
RISKS WHEN PREGNANCY OCCURS QUICKLY AFTER AN ABORTION OR MISCARRIAGE, COMPARED TO RISKS AFTER WAITING 6 MONTHS		
Increased Risk After 1-2 Mos. Interval	Increased Risk After 3-5 Mos. Interval	
Low Birth Weight	170%	140%
Maternal Anemia	160%	120%
Preterm Birth	80%	40%
<small>Sources: Conde-Agudelo, et al, 2000, 2005, 2006; Da Vanzo, et al, 2004; Razzaque, et al, 2005; Rutstein, 2005.</small>		

World Health Organization (WHO) Recommendations

Based on a review of six USAID-supported studies, WHO produced a policy brief in 2006 on birth spacing which included the following preamble and recommendations:

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 an 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

In addition to the two recommendations in the WHO policy brief, ESD operational messages include a 3rd message for adolescents – “for adolescents, the recommended time period for the first pregnancy is at least 18 years of age or older.”

Within the context of informed choice about spacing or limiting future pregnancies, *for those who choose to space*, the above recommendations in the 2006 WHO Policy Brief, in conjunction with the preamble should be incorporated into counseling and behavior change communication messages.

Birth Spacing Trends and Demand and Unmet Need for Spacing

High percentages of mothers and newborns are at risk of adverse health outcomes due to too closely spaced pregnancies

In Pakistan, about 1 in 3 births occur within less than 24 months after a previous birth.

International data show that there is 170 to 300% increased risk of a neonatal, post-neonatal or infant death associated with birth-to-birth intervals of less than 18 months.

Short birth intervals have returned to the same high level seen in the early 1990s.

The portion of births occurring less than 24 months after a previous birth, and associated with very high health risks, decreased by 40% between 1991 and 2001, only to rebound to relatively high levels (33.7% or 1 in 3 births) in the 2006/07 survey. The shortest birth interval is born to women age 15-19 (21 months).

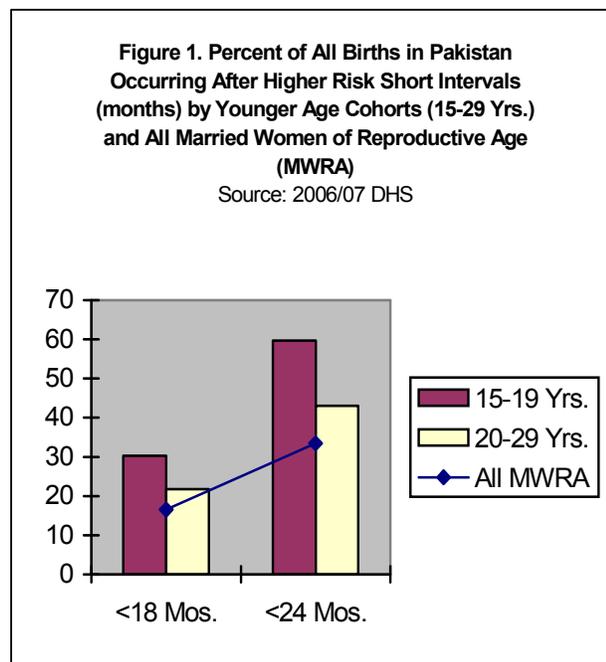
Demand for spacing increasing, but slowly

Over the 1990 to 2001 period, the total demand for spacing among all reproductive-age married women registered a 50% increase, going from about 13% to nearly 19%.

However, overall demand for spacing remains low. By 2001, the demand for spacing among 15 to 29 year old women (at 24%) was 28% greater than that found among all married, reproductive-age women, and in 20-24 year olds, spacing demand was nearly twice as high (at 36%). Analysis of data from several developing countries shows that demand to space among even young, zero-parity women is common (Jansen 2005).

Need for family planning access remains

According to the 2006/07 Pakistan Demographic and Health Survey, about 30% of all married women of reproductive age in Pakistan currently use any contraceptive method. Use of modern methods is about 22%. Among 15 to 19 year old married women, less than 1 in 10 (6.7%) use any contraception. Use of contraception among zero-parity women is virtually nil, at 0.6%. Data from a 2000/01 survey shows that, although unmet family planning need for spacing among the total population of married women of reproductive age remains low (around 12%), the unmet need for spacing in the younger age cohorts (15-29) is about two thirds higher, running around 21%.



Spacing Patterns and Programmatic Ramifications

A major reproductive health issue

All available data and information indicate that the higher risks of short birth intervals and early pregnancies represent a major reproductive health issue in Pakistan. The problem of short birth intervals is even more pronounced in younger women, among whom the highest risks from very short birth intervals are more common. Although contraceptive prevalence has increased from 2002, it is likely that the majority of existing demand for spacing still goes unmet and the high frequency of short birth intervals demonstrates how much further family planning services must progress to better address birth spacing needs.

Strategies are needed

To reduce the current number of pregnancies that occur less than recommended intervals, couples will need easier access to spacing services that are responsive to their circumstances. Since most of the births occurring among women 15-19 years old are first births, the main issue for this age cohort is the timing of the first pregnancy. Communication, counseling and services for adolescents should focus on the health risks associated with the timing of a first pregnancy and birth.

Program research findings to date

Operations and survey research indicate that when women and their families are advised of the health and quality of life benefits of pregnancy delay and spacing, use of family planning increases substantially. One study conducted in India found that use of contraception for delaying the first child increased from 5% to 20% over 4 years in the intervention area, and from 4% to 8% in the control area. The same study found that use of contraception for spacing the second child increased from 14 to 33% in the intervention area and from 10 to 20% in the control area. A project in Egypt, implemented from 2003-2005, which improved the quality of services, and included HTSP counseling and community outreach among influential leaders, was found to have increased the contraceptive prevalence rate from 50 to 80% among all married women of reproductive age and from 38 to 73% among young, low-parity women. Similar studies are underway in Egypt, India, Yemen, Nepal, and Bangladesh.

Implications for Program Design

These statistics inform the following recommendations:

- **Explore reasons for dramatic increase** in number of births occurring within less than 24 months after a previous birth, and utilize findings in program design.
- **Present HTSP data to decision-makers**, to advance understanding of the role of pregnancy timing and spacing in the health of mothers and newborns in Pakistan.
- **Implement HTSP behavior change communication** and counseling interventions as an integral risk prevention strategy in all family planning, child and maternal health communications and client counseling protocols.
- Ensure that the two 2006 **WHO pregnancy spacing recommendations**, as well as information on the specific health benefits associated with the healthy timing and spacing of pregnancy are included in all communications and protocols.
- **Develop or strengthen** pregnancy delay or spacing services and communication activities for young (15-29 years) clients.
- To achieve a more balanced method mix, **help families understand** that long-acting and intermediate methods (IUDs and injectables) are safe, and can effectively help them achieve their spacing preferences.
- **Expand communications and service delivery efforts** among zero-parity adolescents that are oriented to health risks associated with the timing of a first and subsequent pregnancy.
- Use this HTSP Profile in advocacy with national policymakers and district health teams, to **advocate for increased resources for HTSP interventions**.

Definitions

Unmet need for spacing: The percentage of currently married women who want to wait before having their next birth and are not using any method of family planning. Included with the unmet need for spacing are pregnant women whose pregnancy was mistimed; amenorrheic women whose last birth was mistimed; and, fecund women who are neither pregnant nor amenorrheic, not using any method of family planning, and who want to wait two or more years for their next birth. Unmet need for spacing also includes fecund women who are not using any contraception and are unsure whether they want to have another child or who want another child but are unsure when to have the next birth.

Demand for family planning for spacing: The sum of current contraceptive prevalence for spacing (including currently pregnant or amenorrheic women whose pregnancy or last birth was the result of a contraceptive failure) and the unmet need for spacing.

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Contact information:

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

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