

## Healthy Timing and Spacing of Pregnancy (HTSP) in Nepal

**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 Nepal:

- Among married women of reproductive age (MWRA) 22% of births are spaced <2 years apart
- Among mothers between 15 and 19 years old, 60% of births are spaced <2 years apart
- During the last ten years births occurring too soon experienced a slight decrease (9%).
- The total desire to space pregnancies among married women decreased by 17%.

#### 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 Nepal.

Annual number of births*	787,000
Annual number of neonatal deaths**	21
Neonatal mortality rate*	165,270
Annual number of infant deaths (includes neonatal)**	74
Infant mortality rate*	56
Annual number of <5 deaths (includes both infant and neonatal deaths)*	40
Child mortality rate*	58,000
Annual number of low birth weight infants**	43,890
% of infants with low birth weight*	31,350
Annual number of maternal deaths**	740
Maternal mortality rate (UNICEF adjusted #)*	5,820
Lifetime risk of maternal death when a woman becomes pregnant*	1 in 24

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

Sources: \*UNICEF, 2007 State of the World's Children  
\*\* Calculated from UNICEF data

## 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 3<sup>rd</sup> 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***

About 22% of pregnancies in Nepal occur less than the recommended interval (see Figure 1). Among 15-19 year olds, approximately 60% of births occur too soon. 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.

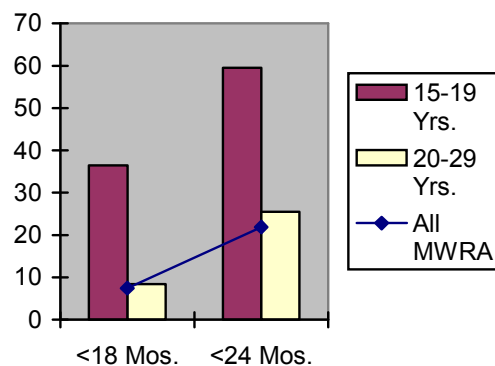
### ***Nepal is making progress in addressing its birth spacing issues.***

The portion of births occurring less than 24 months after a previous birth, and associated with very high health risks, decreased by 9% between 1996 and 2006. During the same period the rate of adolescent pregnancies in Nepal also declined by 23%.

### ***Demand for spacing decreasing***

Over the 1996 to 2006 period, the total demand for spacing among all reproductive-age married women registered a 17% decrease, which indicates that couples may not have a good understanding of the health risks associated with short pregnancy intervals. Analysis of data from several developing countries shows that demand to space among even young, zero-parity women is common (Jansen 2005).

**Figure 1. Percentage of All Births in Nepal Occurring After Higher-Risk Short Intervals (months) by Younger Age Cohorts (15-29 Yrs.) and All Married Women of Reproductive Age (MWRA)**  
Source: 2006 DHS.



### ***In Nepal younger women have unmet need for family planning***

Younger women face unnecessary health risks on both the *timing* and *spacing* of pregnancies. Although Nepal experienced a decline in the pregnancy rate among 15-19 year olds, almost 1 in 4 women (23%) report having had their first child by the time they were 18 years old and 60% of births to 15-19 year olds are spaced less than 2 years apart. According to the 2006 DHS, about 1 in 3 married women of reproductive age in Nepal use a modern contraceptive method, however, less than 1 in 20 (4.5%) of 15-19 year olds are current users of modern contraceptives.

## 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 Nepal. 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, 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**

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These statistics inform the following recommendations:

- **Explore reasons for decreased demand of spacing.**
- **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**

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**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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