Providing Reproductive Health Services to Young Married Women and First-time Parents in West Africa

A Supplemental Training Module for
Community Workers
Conducting Home Visits

Pathfinder INTERNATIONAL

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Contents

Acronyms and Abbreviations

DHS	Demographic and Health Survey
FTP	First-time parent
HTSP	Healthy timing and spacing of pregnancy
SRH	Sexual and reproductive health

Notes for Organizers and Trainers

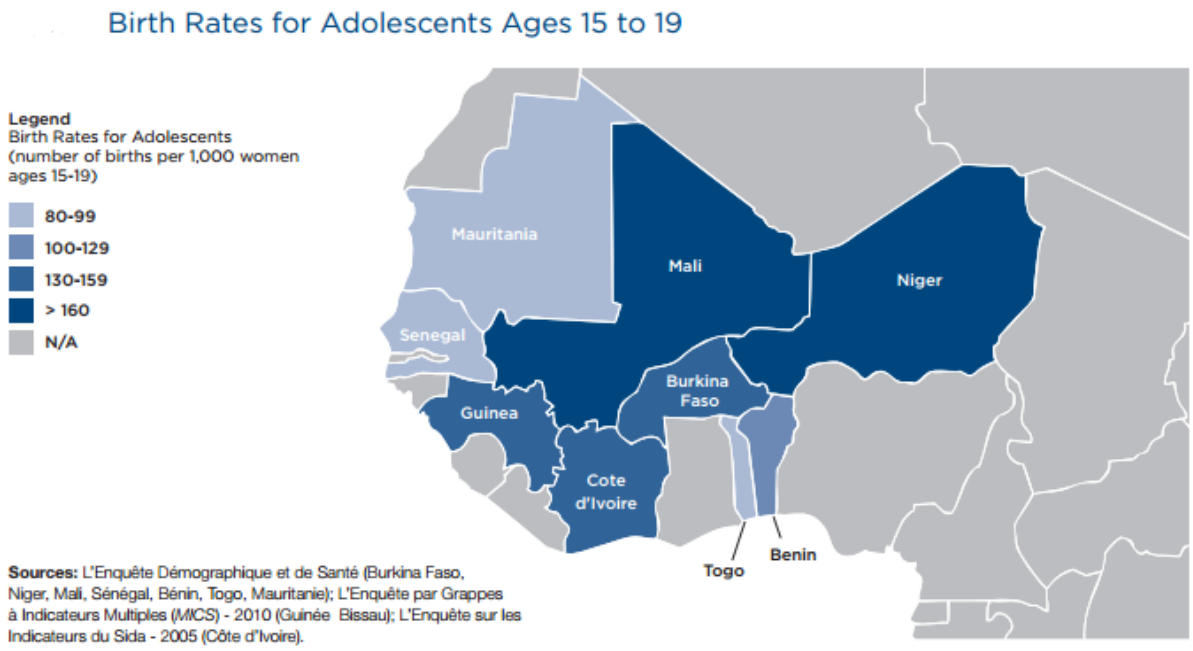
Background

In much of francophone West Africa, a significant proportion of adolescent girls aged 15–19 and young women aged 20–24 are married or living in union. For most young women, sexual debut and childbearing occur within the context of marriage (formal and informal unions in which a man and a woman are living together). Use of modern contraceptives is low among young married women and adolescents and childbearing usually begins soon after marriage. See the table below for a selection of data on marriage, childbearing, and contraceptive use in several francophone West African countries.

	Minimum age of marriage for girls	% adolescent girls aged 15–19 who are married/in union	% women aged 20-24 who are married/in union	% women 20–24 who gave birth by 18	% women 20–24 who gave birth by 20	% married adolescents 15–19 using modern method
Burkina Faso (DHS 2010)	15	31.5%	81%	28%	57%	6%
Guinea (DHS 2012)	17	35%	76%	40%	59..6%	2.6%
Cameroon (DHS 2011)	15	24.2%	61.8%	29.9%	49.4%	12.2%
Niger (DHS 2012)	15	70%	90.5%	48.2%	73.9%	5.9%
DRC (DHS 2007)	15	22.5%	65.3%	23.3%	48.3%	16.1%
Côte d'Ivoire (DHS 2011-12)	18	20.7%	56%	31%	50.2%	6.9%
Senegal (DHS 2012-13)	16	22.6%	56.7%	17.7%	34.3%	2.8%
Mali (DHS 2012-13)	16	43.1%	84.5%	46.2%	68.2%	6.5%
Benin (DHS 2011-12)	18	13.8%	61.4%	23.3%	41.6%	4.2%

First-time parents (FTPs) may be married or unmarried, are either pregnant with or have had their first child, and are 10–24 years of age (although the male partner may be much older in certain contexts). The map below gives an overview of birth rates among adolescent girls aged 15–19 in a number of francophone West African countries.[1]

[1] Map source: Ouagadougou Partnership, *Family Planning: Francophone West Africa on the Move – A Call to Action* (2012). Available at: http://www.prb.org/Publications/Reports/2012/ouagadougou-partnership-en.aspx



Young married women and first-time parents face a unique set of challenges to living healthy sexual and reproductive lives — challenges that are different to those faced by unmarried adolescents or older married women. When they get married, young women quickly become isolated, with household responsibilities and limitations on their mobility keeping them at home without supportive social networks or access to health information and services. Furthermore, the choice of whether or not to use contraception to plan when and if they want to have children is rarely their own. Their husbands, co-wives, community and family elders, in-laws, and religious leaders have most of the decision-making power (or influence) related to sexual and reproductive health (SRH) and they also often decide how resources within the household are used. These unequal power dynamics and gender inequalities place young married women and first-time mothers at particular risk of gender-based violence, gender-based household maltreatment, pressure to bear children before they are ready and prevention of pregnancy spacing. As a result of these dynamics and other factors (including sociocultural preferences around fertility and provider bias), many young in-union or married women become parents during their youth and young mothers have closely spaced pregnancies, compromising their health and that of their newborns. Significant evidence posits that both mother and baby are healthier if at least 24 months passes between pregnancies.[2,3,4,5]

Despite the need for health services and community-based programming to address gender and other social norms, few programmatic efforts intentionally address the needs and rights of young married women and first-time parents. Educating health providers about the needs of married

[2] WHO. *Report of a technical consultation on birth spacing.* (Geneva: WHO, 2005). Available at: http://www.who.int/maternal_child_adolescent/documents/birth_spacing.pdf?ua=1.
[3] UNFPA. How Universal is Access to Reproductive Health? 2010. Available at: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/universal_rh.pdf.
[4] Conde-Agudelo A and Rosas-Bermudez A. "Effects of Birth Spacing on Maternal, Perinatal, Infant and child Health: A Systematic Review of Causal Mechanisms." *Studies in Family Planning*. 2012 43[2]: 93–114
[5] Cleland J, et al. "Contraception and health." *The Lancet*, 2012 380: 149-156.

adolescents has been shown to increase both provision and utilization of antenatal and SRH services aimed at young married women and first-time parents.[6]

Purpose

This supplemental two-day training is designed for community workers who have already been trained in contraception, reproductive health, and client counseling. The goal of the supplemental training module is two-fold:

1. Improve community workers' capacity to offer high-quality, nonjudgmental counseling to young married women (10–24 years) and those who have had their first child (i.e., first-time parents) through home visits.
2. Improve community workers' capacity to provide counseling and information to the key influencers of the reproductive lives of young married women and first-time parents through home visits and community activities.

For the purposes of this training module, the term **young married women** refers to those young women (aged 10–24) in formal and informal unions in which they are cohabitating with a partner. This group includes those with and without children. The term **first-time parents** (FTPs) refers to any young person aged 10–24 who is pregnant with or has had a child for the first time, regardless of marital status. This training module was designed for 15–25 participants. It is recommended that approximately 15-20 people participate in one training session. If there are more than 25 participants, the trainer will need to modify some of the activities.

Learning objectives

At the end of this two-day supplemental training, participants will be able to:

1. Describe the specific challenges young married women and first-time parents face to living healthy reproductive lives.
2. Explain the three main messages of healthy timing and spacing of pregnancies (HTSP).
3. Demonstrate appropriate, nonjudgmental, and comprehensive counseling for young married women and FTPs regarding their reproductive health.
4. Identify the key influencers of young married women's and FTPs' on reproductive health decision-making.
5. Describe strategies to increase acceptance of HTSP and the use of contraception among key influencers (e.g., husbands, mothers-in-law, and others) on young married women's and FTPs' reproductive health.

[6] The ACQUIRE Project, "Mobilizing married youth in Nepal to improve reproductive health: The Reproductive Health for Married Adolescent Couples Project, Nepal, 2005–2007," *E&R Report No. 12* (New York: EngenderHealth/The ACQUIRE Project, 2008).

Components of the module

This supplemental module consists of the trainer's guide (this document), participant handouts (see Annex 1 of this document), and a PowerPoint Presentation that can be used if the trainer so desires (available on Pathfinder International).

Overview of sessions

Session and activities	Duration	Supporting resources
Session 1: Introduction to the module	15 minutes	Slide 1-1 Participant Handout 1
Session 2: Understanding the needs of young married women and FTPs, and the challenges that they face	150 minutes (2.5 hours)	Activity 2-1 Tools A and B Tape Slide 2-1 Participant Handout 2
Session 3: Attitudes and values related to young married women and FTPs regarding fertility and contraception	90 minutes (1.5 hours)	Agree/Disagree signs for each participant
Session 4: Healthy timing and spacing of pregnancy	90 minutes (1.5 hours)	Participant Handout 3 Slides 4-1 and Review Game Slides Colored papers Small prize
Session 5: Counseling young married women and FTPs, and their key influencers	330 minutes (5.5 hours)	Participant Handout 4 Participant Handout 5 Participant Handout 6 Slides 5-1, 5-2, 5-3
Session 6: Review and conclusion	45 minutes	
Total time	**12 training hours**	

Adapting this training

This training was originally developed for working in Burkina Faso, Guinea, and Niger. However, it can be relatively easily adapted to fit contexts in other francophone West African countries, or—with a little more effort—countries outside that region. There are several specific places where adaptation may be needed, depending on the country and context:

Country-specific information: When introducing the training, you can share statistics from your specific country or setting. You can draw on the information in the table in the Background section, which shares relevant statistics on early marriage, childbearing, and contraceptive use in various countries.

Case studies and role plays: You may want to change the names that are used in the case studies and role plays ("Augustine" and "Harouna" in Session 2, Activity 2-1; "Fatimata" in Session 2, Activity 2-2; "Mariam," Karim," and "Salimatou" in Activity 5-1; and "Hawa," "Oumar," "Ousmane," and "Korotini" in Activity 5-2). Depending on the typical age of marriage in the community you are working in, you may want to change the ages of these characters. Depending on the religion(s) of your target community, you may also want to change the references to Islam and Muslim religious leaders. Similarly, if polygamy is not common in your target community, you may want to change those details in both of the above activities.

Information about your project and implementation of home visits: You will probably need to adapt content in Session 5, depending on your project design and your specific plans for implementing the home visit approach (e.g., frequency of visits, supervision, reporting).

Illustrative training schedule

This supplemental module is designed to be used with community workers who have already been trained in contraception, sexual and reproductive health, and counseling skills. This two-day module can be added to a comprehensive sexual and reproductive health training, or it can be used as a separate refresher training session. The schedule below is illustrative and can be modified by the trainers to fit the circumstances of the training.

Illustrative Training Schedule

Day One	
Time	**Session and activities**
9:00-9:15	Welcome and introductions
9:15-9:30	Session 1: Introduction to the module
9:30-10:30	Session 2: Understanding the needs of young married women and FTPs and the challenges that they face Activity 2-1
10:30-11:00	Break
11:00-12:30	Session 2: Understanding the needs of young married women and FTPs and the challenges that they face Activity 2-2 and Activity 2-3
12:30-1:30	Lunch
1:30-3:00	Session 3: Attitudes and values towards young married women and FTPs regarding fertility and contraception
3:00-3:15	Break
3:15-4:00	Session 4: Healthy Timing and Spacing of Pregnancy Activity 4-1
4:00 – 4.45	Session 4: Healthy Timing and Spacing of Pregnancy Activity 4-2
4:45-5:15	Daily wrap-up

Day Two	
Time	**Session and activities**
9:00-9:15	Welcome and summary of the previous day, review of 2nd day
9:15-10:00	Session 5: Counseling young married women and FTPs and key influencers Activity 5-1
10:00-10:45	Session 5: Counseling young married women and FTPs and key influencers Activity 5-2
10:45-11:00	Break
11:00-1:00	Session 5: Counseling young married women and FTPs and key influencers Activity 5-3
1:00-2:00	Lunch
2:00-4:00	Session 5: Counseling young married women and FTPs and key influencers Activity 5-4
4:00-4:30	Session 6: Review and Conclusion

Session 1: Introduction to the Module

Objective of the session:

1. Introduce participants to the supplemental training module

Before the training, the trainer should:

- Review the training content and familiarize yourself with the material and methodologies.
- Adapt the training content and schedule so that it meets your project's specific needs.
- Review **Slide 1-1**.
- Make enough copies of **Participant Handout 1: Training Schedule** for all participants.

Total session time: 15 minutes

Activity 1-1: Introduce the participants to the supplemental training module on young married women and first-time parents (FTPs)

Time: 15 minutes

Methodology: Trainer presentation

The trainer should:

1. **Introduce the session by reading aloud the content below to the participants.** (You may want to add country-specific data, drawing from the table in the Background section.)

In much of francophone West Africa, a significant proportion of adolescent girls aged 15–19 and young women aged 20–24 are married or living in union. For most young women, sexual debut and childbearing occur within the context of marriage (formal and informal unions in which a man and a woman are living together). Use of modern contraceptives is low among young married women, and childbearing usually begins soon after marriage. For the purposes of this training, the term **young married women** refers to young women (aged 10–24) in formal and informal unions, in which they are living with a partner. This group includes both those with and those without children. The term **first-time parents** (FTPs) refers to any young person aged 10–24 who is pregnant with or has had a child for the first time, regardless of marital status.

Gender and socioeconomic inequalities render this group of young people particularly vulnerable throughout West Africa, and these young women experience significant pressure from key influencers, such as mothers-in-law, husbands, and sisters-in-law to bear children early and frequently.

In your role as a community worker, you will be asked to conduct home visits to young married women and FTPs, and you will also be asked to conduct group counseling and education sessions with husbands, mothers-in-law, and other influencers. This module will provide an opportunity for further exploration of the specific challenges young married women and FTPs face to living healthy reproductive lives and will provide you with the skills needed to offer the necessary counseling to support changes in behavior related to healthy timing and spacing of pregnancies.

1. **Display Slide 1-1 (Session 1, Slide 1) and explain the training objectives using the content below:**

At the end of this 2-day supplemental training, you will be able to:

1. Describe the specific challenges young married women and first-time parents face to living healthy reproductive lives.
2. Explain the three main messages of healthy timing and spacing of pregnancies (HTSP).
3. Demonstrate appropriate, nonjudgmental, and comprehensive counseling for young married women and FTPs regarding their reproductive health.

4. Identify the key influencers on young married women's and FTPs' reproductive health decision making.
5. Describe strategies to increase acceptance of HTSP and contraceptive use among key influencers (e.g., husbands, mothers-in-law, and others) on young married women's and FTPs' reproductive health.

2. Ask participants if there are any questions

3. Pass out and review Participant Handout 1: Training Schedule

Session 2: Understanding the Needs of Young Married Women and FTPs, and the Challenges They Face

Objectives of the session:

1. Understand the ways that community norms and different types of people influence the decision making of young married women, FTPs, and their husbands/partners.
2. Increase participants' awareness and understanding of the needs and challenges young married women and FTPs face to living health reproductive lives.
3. Describe why it is important to provide young married women and FTPs with comprehensive, nonjudgmental reproductive health counseling and services.

Before the training, the trainer should:

- Review the training content and add any country-specific data that you think will be useful.
- Obtain flipchart paper.
- Bring masking tape, chalk or something else that you can use to mark/draw on the floor.
- Photocopy and cut out the 25 character name tags from **Activity 2-1 Tool A: Circles of Influence Name Tags.**
- Prepare 25 pieces of tape in advance.
- Photocopy and cut out the character statements from **Activity 2-1 Tool B: Circles of Influence – Character Statements.**
- Fold the character statements in half so no one can read them, and clip or pile each one with the corresponding name tag/paper. Create 25 small piles for participants to choose from alongside the 25 pieces of tape.
- Print **Participant Handout 2: Case Study - Fatimata**

Total session time: 2 hours and 30 minutes

Activity 2-1: Circles of influence around young married women, first-time parents, and their husbands/partners[7]

Time: 1 hour

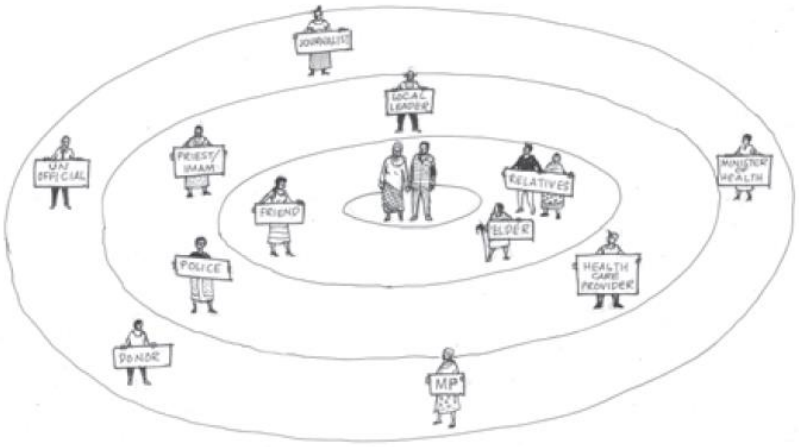
Methodology: Participatory activity

The trainer should:

1. **Introduce the session by reading this content to the participants:**

This training module focuses on building knowledge and skills related to the reproductive health needs and rights of young married women and FTPs. But young married women in West Africa are heavily influenced by powerful people in their lives, and community norms which perpetuate gender inequality and value early and frequent childbearing. This first exercise will allow us to explore how the thoughts, beliefs, and actions of others create community norms and how those norms and the people who perpetuate those norms might influence young married women and first-time parents. In the next activities in this session we will look more closely at the challenges young married women and first-time parents might face in seeking health services and we will discuss why it is important to work with this population.

2. **Draw or mark four concentric circles on the floor as shown in this drawing**.[8]



3. **Lay out the character nametags and the corresponding character descriptions that you prepared before the session began. Give each participant the following:**
    a. A Character Nametag
    b. The corresponding Character Statement. This should have the same number as the Character Nametag they received. For example, the participant who receives "1. Augustine (young married woman)," should receive the piece of paper numbered "1" with the description of Augustine's character.

[7] Adapted from the SASA! Methodology Training Prep Module. Available from: http://raisingvoices.org/sasa/
[8] Illustration from SASA! Training Prep Module. Available from: http://raisingvoices.org/sasa/

c. A piece of tape.

4. **Once each participant has a Character Nametag and the description of their character, have them tape their nametag to their chest. Tell them they can read their character descriptions on their corresponding pieces of paper, but only to themselves.**

   ***Note to the facilitator*:** If you have a group that is smaller than 25, it is okay if not all the name tags are used, but be sure that some participants are given higher numbers (21-25) in order to complete the exercise.

5. **Ask the participants who have the nametags that say "1. Augustine (young married woman)" and "Harouna (husband)" to stand inside the smallest, innermost circle.**

6. **Tell the participants: This young married woman is named Augustine. She is 16 years old and recently married Harouna who is 40 years old.**

7. **Say the following to the participants:**

Now, all of you have a nametag of a type of person who might have some kind of influence on the life of Augustine and Harouna, and specifically on their decisions about when and if to have children. You can see that we have four circles on the ground. The circle closest to the couple is where the people who are most influential on their decisions should stand. The people who have a little bit less influence, but still have *some* influence, should stand in the next circle out (the middle circle). Finally, people who have less influence on the couple, but still influence the community and country in which they live in should stand in the last, outermost circle. When I say "GO" you should all stand up and go to where you think you should stand based on your character. Discuss amongst yourselves to determine where everyone should stand based on the reality in your community. The people who influence the couple the most should be standing closest and those with less influence should be further away. If there are any very influential people missing from the list, you can discuss and add them if the group agrees.

8. **Say "Go." Allow the group about 10 minutes to arrange themselves in the way that they think illustrates the level of influence in their community. Allow them to debate and discuss amongst themselves.**

9. **When the group is done, read the following to the group:**

First, I will ask Augustine and Harouna to introduce themselves by reading out loud what is written on their character description papers.

When they are done, I will ask another participant to introduce her/himself to the group and read his/her character description paper aloud looking at Augustine and Harouna.

After that first person is done, she will tap the shoulder of someone else near them. That person will then read his/her paper and tap someone else on the shoulder. We will do that until everyone has had a turn to read their paper.

Note to trainer: *If the facilitators are not comfortable reading the paper, the trainer can read out the description for each of the different people.*

10. **Once everyone has had a turn, ask participants to sit down. Facilitate a discussion with the group using these questions:**
    - How was this exercise like real life in your community? Does it seem similar to life in your communities?
    - What does this exercise tell you about a young married woman or young mother's ability to make choices about when and if to have a child?
    - How is she influenced and pressured by those people around her?
    - "Gender norms" are the roles and behaviors that society thinks are appropriate for men and boys and women and girls. "Gender inequalities" are the differences in power that men and boys may have in comparison to women and girls.
        i. How do gender norms and gender inequalities play a role in the ability of Augustine to make reproductive health decisions?
    - Who are the most powerful influencers of young married women and first-time mothers in your community? Who pressures them to have children soon after marriage and to have many children before they grow older?
    - Who might provide positive support for young married women to practice healthy timing and spacing of pregnancies?

11. **Summarize the discussion by reading these key points to the participants:**

All around us are circles of influence: family and friends, community members, and society. People at each of these level influence a young married woman or fitst-time mother's ability to make choices with her partner about when and if to have children. As a community worker, it is your role to understand the different pressures a young woman might feel, and counsel that young woman to help her navigate those different pressures. In addition, it is your job to work with the most influential people to help create an environment that is supportive to young women to make joint decisions about fertility and reproductive health with her partner.

Activity 2-1 Tool A: Circle of Influence Nametags

1. Augustine
(young married woman)

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2. Harouna
(husband)

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3. Harouna's mother
(Augustine's mother-in-law)

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4. Harouna's friend

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5. Augustine's father

6. Harouna's sister

(Augustine's sister-in-law)

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7. Harouna's father

(Augustine's father-in-law)

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8. Augustine's mother

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9. First wife of Harouna

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10. Imam

11. Health care provider

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12. Leader of the community women's group

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13. Police officer

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14. Neighbor

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15. Market seller

16. Teacher

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17. Traditional leader

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18. Small group leader / peer educator

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19. Augustine's former friend when she was in school

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20. Friend of Augustine's mother-in-law

21. Judge

---

22. NGO staff

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23. Radio announcer

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24. Parliamentarian

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25. District Health Official

Activity 2-1 Tool B: Circle of Influence: Character Statements

1. My name is Augustine. I am married to Harouna. Harouna seems like a nice man, but I was so sad to leave school and all my friends to get married. I'm lonely now. I know it is expected that I have a baby as soon as possible, but I'm scared. I heard that having a child so young can be harmful to me and my baby.

2. My name is Harouna. I am married to Augustine. She is my third wife. I'm very happy to have married her so I can become a father again soon.

3. I am Harouna's mother (Augustine's mother-in-law). Augustine, you are part of our family now. We expect you to prove you are worthy of our son and produce a child quickly.

4. I am Harouna's friend. He is a good man and well-respected in our community. Augustine, you must honor him and produce a male child for him so that he continues to be well-respected.

5. I am Augustine's father. I didn't want to marry you off so young. I always hoped I could let you finish school. But things were difficult in our family and I had two sons to support and your younger sister. It was time for you to go. I hope you show this man that you were raised by a good family and bring honor to our home by proving you are a woman soon.

6. I am Harouna's sister. You look nice, but not good enough for my brother. I hope you will prove to me that you are good for my family.

7. I am Harouna's father. My son has brought wealth to our family. I hope you will bring another male heir to perpetuate our lineage.

8. I am Augustine's mother. I wish you good luck in your new home. May Allah help you with your new duties. It is important to respect your husband and accept his wishes. But, I also hope you will have good health.

9. I am the first wife of Harouna. I am already blessed with many children with Harouna. My son is almost a man now. No woman can be better than me for Harouna.

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10. I am the Imam in Augustine and Harouna's community. May Allah bring many children to bless you very soon.

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11. I am the health care provider. You know it is very risky to have a birth so young, it can lead to unhealthy baby and can put you at risk of death or problems like fistula. It is recommended to wait until you are at least 18 to have a baby. If you can come to the clinic I can tell you about many family planning options.

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12. I am the leader of the local women's group. Only real women with many children are welcome in our group.

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13. I am a police officer. I am supposed to prevent early marriages, but I'm from this community and I know it is our culture.

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14. I am a neighbor of Harouna. I am wondering why you refuse to become pregnant.

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15. I am a seller in the market nearby. I believe that women and men are not equal. When I see a woman trying to tell her husband what to do, I tell everyone that she is a bad wife who is not to be respected.

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16. I am a teacher. I see girl after girl drop out for marriage. I wish they could delay pregnancy and continue in school.

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17. I am a traditional leader. It brings honor to our tribe when young women bring babies into the world.

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18. I am a community worker. I am here to talk to you Augustine and Harouna and counsel you on your problems. It is healthy for you to wait to have a child until you are 18. I can tell you more about family planning.

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19. I am an old friend of Augustine when we were in school. I miss you now that you are married. It seems that married girls never leave the house. I know it will be even worse once you have a child. I hope you are able to wait to have a baby until you are older so you don't have the same problems like our friend Binta had when she gave birth.

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20. I'm friends with Augustine's mother-in-law. Augustine, your mother-in-law is telling everyone that you don't want a baby right away and that you aren't good for her son.

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21. I'm a judge. Marriage before the age of 18 is illegal here. If a case is brought to me, I will try to disrupt the marriage.

---

22. I am an NGO worker. We tell people they should practice health timing and spacing of pregnancies and consider using family planning. I don't understand why it isn't easy for young married women to just use contraception to delay the pregnancy and prevent health problems.

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23. I am a radio announcer. You hear my messages every day. We joke about women who don't produce children right away. What is the harm in joking?

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24. I'm a parliamentarian. We put a law in place to prevent child marriage. The judges should respect and apply the law. I don't know what else we can do.

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25. I am a district health official. It is not my priority to make services friendly to young married women. Currently, only older women with several children use our health centers.

Activity 2-2: Understand the challenges young married women face and FTPs in seeking reproductive health services

Time: 45 minutes

Methodology: Case study and discussion

The trainer should:

1. **Read the following content to participants:**

   Now that we have understood more about the kinds of pressure young married women and FTPs face to bear a child quickly, let us discuss more about the barriers that these young women face when trying to seek health services. I will read a case study about a young woman named Fatimata to you. As I read the case study, please write down or think about each of the barriers that Fatimata faces while trying to access contraceptive services. The barriers can be within her home, her community, and at the health facility.

2. **Pass out Participant Handout 2: Fatimata Case Study and read the case study about Fatimata (also found on the next page) to participants.**

3. **After reading the case study, ask the participants if they had time to write down all of the challenges that they could think of. If not, give them another 5 minutes, and read the case study out again if necessary.**

4. **Ask participants to share some of the challenges they wrote down.**

5. **After participants have shared, lead a discussion with them, using the following questions. Ask each question aloud and allow the group to discuss their answers to the questions.**

   - Could the story in this case apply to young married women in your community? Why or why not?
   - What do you think Fatimata is thinking and feeling during this experience?
   - Who might be pressuring or influencing the decisions that Fatimata wants to make?
   - Who might be pressuring Fatimata's husband's decisions about when and if to have a baby?
   - What might be some of the health needs of Fatimata and other young married women in your community?
   - What do you think the community worker in Fatimata's community could have done differently to prevent Fatimata from having this negative experience?
   - What support would be useful to Fatimata and other young married women and FTPs at the community level?

6. Conclude the activity by reading this out loud:

When a young woman enters a marriage or has a child, her life and the life of her partner can change both positively and negatively. Depending on the person's support structure, culture, economic situation, and personal relationships, a new relationship can create challenges for which he or she may not be prepared. As we demonstrated with the first exercise and as we discussed in this case study, young women and their husbands/partners often experience pressures and influences that are different from unmarried young people or older married women, particularly around childbearing. As a community worker, it is important to understand these pressures and provide supportive counseling for young women in order for them to live healthy reproductive and sexual lives.

Case study: Fatimata (also Participant Handout 2)

My name is Fatimata. I am 17 years old. I have a baby girl who is 1 year old. I have been married to my husband for two years. I am the youngest of my husband's three wives. I love my baby girl, but I worry about her a lot because it seems like she is always sick. My husband's mother is always asking when we will have our next child. She says that the baby will start running everywhere soon, so it is time.

I know I need to have another baby, especially because my first baby is a girl. But, I know that having another baby soon will be very hard for me and my little girl, since she has been so sick. It will mean that I will have to make the small amount of food we have stretch even further.

I heard you could get a shot to avoid having a baby for three months, but I don't know anything about it. There are some community health workers working in my community, but they are older women who are friends with my mother-in-law, and I know my husband and mother-in-law would disapprove if they knew I wanted to learn more about the medicine to prevent pregnancy. I don't have any friends to talk to about this. I hardly even leave the compound. All my friends from school are also married and live far away.

I was scared, but I decided to try to go to the nearest health center. I hoped that I wouldn't see people I knew there. I told my husband and mother-in-law that the baby was sick and walked the 10 km to the nearest health center.

I went to the health center early in the morning because I needed to go back home and do household chores before it became too late in the day. When I arrived, there were several women waiting outside with many children. They kept looking at me.

The health center staff was late to arrive. I waited for an hour. When the facility opened, I got up enough courage to speak to the woman behind the table with a sign saying "Reception." She asked me why I was at the clinic when my baby wasn't sick. When I explained that I wanted to talk with the nurse about family planning, she made a disapproving face and just pointed to the consultation waiting area.

I waited for two hours near the family planning room. I hadn't eaten anything and my baby started to cry. I felt that all the older women were staring at me. One of the women recognized me. She is a friend of my mother-in-law and asked me why I was there since the family planning services are for older women who are ready to stop having children, not a young woman like myself who should have another child while I'm still young.

I was finally called in to speak with one of the nurses. When I went into the consultation room, the nurse looked angry. She asked me why I was here. I told her that I didn't want to be pregnant so soon after my last baby and I had heard there was some kind of shot I could get. She asked if my husband had given me permission to be there. I looked down and told her that I hadn't told him why I was coming. The nurse told me that I had better not use family planning since my husband was certain to find another wife if I didn't have another baby soon, especially since my first baby was a girl. She said I should have all my babies now while I'm young.

I explained that my baby was sickly and it wouldn't be good for us to have another child so soon. The nurse finally said that it is ok for me to use a method and said I should use the three-month injectable, she didn't mention any other method options. I waited for another hour before she gave me the injection, and then the nurse called me in a very loud voice "Fatimata, your injection is ready." I could feel the eyes of the other women in the waiting room staring at me, including that friend of my mother-in-law. I got my injection and left the clinic very embarrassed and worried.

Activity 2-3: Describe why it is important to offer comprehensive, nonjudgmental services to young married women and FTPs

Time: 45 minutes

Methodology: Brainstorm and trainer presentation

The trainer should:

1. **Read the following to participants and as they brainstorm, write their answers on flipchart paper.**

Now that we have discussed the different challenges young married women and FTPs face, let us discuss why it is important for community workers to specifically offer young married women and FTPs comprehensive, nonjudgmental sexual and reproductive health counseling and support. Let's brainstorm some reasons why.

2. **After participants have answered, supplement their responses by showing Slide 2-1 and reading aloud the content below.** (The trainer may wish to add country-specific data to the content regarding: percent of women aged 10–24 who are married and modern contraceptive use by age cohort [15–19-year-olds; 25–29-year-olds; 30–34-year-olds].)

   Reasons why it is important to offer young married women and first-time parents comprehensive, nonjudgmental SRH counseling and services.

   - Young women who are married experience pressures from community, family, and husbands to bear children immediately and often, and often do not practice healthy timing and spacing of pregnancy (HTSP).
   - Young women often have very little power to negotiate their use of health services, when and if to have children or use of contraception in their relationships. This limited power is a result of socio-cultural norms, gender inequality, and the limited power experienced by young women due to age.
   - Young people who are married or have children are often ignored by other programs for youth because they aren't in school or aren't in community-based youth groups. Traditional youth-friendly services are often geared toward unmarried adolescent boys and girls, or those who do not yet have children.
   - Young married women and their partners are just beginning their relationships and reproductive lives together and this is an opportunity to develop lifelong healthy sexual and reproductive practices and better communication among couples.
   - Promoting delay of the first birth and spacing of the second and subsequent births, in addition to joint decision making and communication among young women and their partners can result in an increase in contraceptive use, lower lifetime fertility, reduced maternal mortality, and increased ability for young women to participate in education and economic opportunities.

Session 3: Attitudes and Values Related to Young Married Women and FTPs Regarding Fertility and Contraception

Objective of the session:

1. Reflect on attitudes and values related to fertility, contraception, and decision making among young married women and their partners and first-time parents.

Before the training, the trainer should:

- Review the training content
- Make pieces of paper that are blank on one side, and say either 'Agree' or 'Disagree' on the other. Make enough so that each participant has one card that says Agree, and one that says Disagree.

Total session time: 1 hour and 30 minutes (90 minutes)

Activity 3-1: Exercise to reflect on views and beliefs related to young married women and FTPs, fertility, and contraception

Time: 90 minutes

Methodology: Game

The trainer should:

1. **Explain to the participants that this activity is designed to provide a time to reflect on their own and each other's values and attitudes about the reproductive health issues facing young married women, first-time mothers, and their partners. It is designed to challenge some of the current thinking about the issues facing young married women, couples, and FTPs, and to help them clarify how they feel about certain issues. Remind participants that this is a safe space for open discussion and that everyone has a right to his or her own opinion. Everyone's opinions should be respected, even if there is disagreement.**

2. **Ask the participants to sit in a circle. Give each participant one piece of paper that says "Agree" and one that says "Disagree."**

3. **Read aloud the first statement from the list of statements found below.**

4. **Give participants a few seconds to think about whether they agree or disagree with this statement (repeat the statement, if necessary). Once everyone has had time to make a decision, say "1, 2, 3." When you say "3," each participant should hold up a card. If they agree with the statement, they should hold up the "Agree" card. If they disagree, they should hold up the "Disagree" card.**

5. **Ask for two volunteers (preferably one "agree" and one "disagree") to explain why they chose their answer. Discuss the distribution of answers—did most people pick "agree" or "disagree"? Do the participants think that this reflects the range of opinions within their community?**

6. **Repeat Steps 3 to 5 with the next statement. Continue with each of the statements below.**

Statements

- There are many contraceptive methods that are dangerous for adolescents and youth to use.
- It is acceptable for a young woman to use contraception before she has had her first child.
- Husbands should make the decision about whether or not a couple should use contraception.
- If a married young woman does not have a child in the first two years following her marriage, it is acceptable for her husband to leave her or to seek an additional wife.

- Married young people should not use contraception until they have completed their family size.
- It is acceptable for a community worker to provide SRH advice and care to a young married woman without her husband's permission or knowledge.
- Many contraceptive methods have a long-term effect on fertility.
- It is sometimes appropriate for health care workers to tell a young married woman's family about her sexual or reproductive health

7. After all of the statements have been read, lead the participants in a discussion using the following questions:

- Are there any statements that you found challenging to agree or disagree with? If so, which ones and why?
- How do you think other people in your community might feel about these statements? Would they agree or disagree with you? How do you think your attitudes might affect your interactions with young married women and first-time parents?

8. Conclude by reading the following out loud:

As community workers it is important to understand the pressures that young women face from society to have children, and the challenges they might have in communicating about fertility with their partners, their mothers-in-law, and other influencers. It is also essential that you, as community workers, reflect on the way in which your own biases might influence how you provide services to young people. Health care providers and community workers must reconcile those beliefs with the reality of young women's lives in order to guarantee the right of the young people to receive SRH counseling and services. Remember, young women can use any contraceptive method, though permanent methods are not always the best choice. They can begin using a method before having a child or any time in their reproductive lives. It is healthy for a young woman to delay her first birth until at least age 18 and space subsequent pregnancies by at least 2 years. We can have healthier communities and healthier women and children if young married women and their partners are supported to delay and space their pregnancies by using contraception.

Session 4: Healthy Timing and Spacing of Pregnancy

Objectives of the session:

1. Describe the three key messages of health timing and spacing of pregnancies (HTSP).
2. Summarize the range of contraceptive options for young people.

Before the training, the trainer should:

- Review the training content.
- Make enough copies of **Participant Handout 3: HTSP 101** for all participants.
- Review **Slide 4-1** and **Review Game Slides**.
- Obtain a small prize (e.g., candy) for the winning team in Activity 4-2.
- Prepare three colored pieces of paper for the game in Activity 4-2.

Total session time: 1 hour and 30 minutes (90 minutes)

Activity 4-1: Understand healthy timing and spacing of pregnancy

Time: 45 minutes

Methodology: Trainer presentation

The trainer should:

1. **Present the content below and show Slide 4-1.**

Healthy timing and spacing of pregnancy

Healthy timing and spacing of pregnancy (HTSP) is an approach to family planning service delivery that helps women and couples make an informed decision about delaying the first pregnancy, and timing (spacing or limiting) subsequent pregnancies to ensure the healthiest outcomes for mother and baby. There are three key messages associated with HTSP. These are based on research that determined the healthiest time to begin childbearing and the healthiest amount of time between a birth and the next pregnancy for both the mother and the baby. The three key messages for HTSP are:

1. For couples who desire a next pregnancy after a live birth, the messages are:
    - For the health of the mother and baby, wait at least two years before trying to become pregnant.
    - Consider using a contraceptive method of your choice during that time.
2. For couples who desire a next pregnancy after a miscarriage or abortion, the messages are:
    - For the health of the mother and baby, wait at least six months before trying to become pregnant again.
    - Consider using a contraceptive method of your choice during that time.
3. For a young woman who has not had a child, the messages are:
    - For your health and the health of your future child, wait until you are at least 18 before trying to become pregnant.

When counseling young married women and first-time parents, use the HTSP messages as a guide. Ask young women about when and if they would like to have a child, and talk to first-time parents about when and if they would like have subsequent children. Seek to understand what pressures women might be facing related to their fertility, explain the key HTSP messages, and provide them with options to achieve their fertility goals. This would include guidance on contraceptive options, as well as advice regarding joint decision making within couples, and responding to external influences on reproductive choice.

2. **Review the key messages, by asking participants the following questions:**

   - How long a couple should wait before trying to become pregnant again after a live birth?
     - *Answer: 2 years*
   - After what age is it healthiest for a woman to begin having children?
     - *Answer: For the health of the mother and the baby, delay the first pregnancy to at least age 18.*
   - How long should a couple wait before trying to become pregnant again after a miscarriage or abortion?
     - *Answer: Space pregnancy by at least 6 months after a spontaneous or induced abortion.*

3. **Ask participants to brainstorm what some of the benefits of practicing HTSP are for women, adolescents, and newborns.** The research has shown a considerable reduction in maternal and infant mortality when HTSP is practiced. Following the brainstorm, present **Slide 4-2** and read the content below aloud to participants.

For women:

- Lower risk of maternal death
- Lower risk of pre-eclampsia
- Lower risk of miscarriage

For newborns:

- Lower risk of perinatal death
- Lower risk of pre-term birth
- Lower risk of low birth weight
- Lower risk of small for gestational age

For families:

- More financial security
- Potential for women to continue education or work

4. **Pass out Participant Handout 3: HTSP 101 as a reminder sheet**

5. **Present the content below:**

Most healthy young women can use any method of contraception to practice HTSP. It is the role of the community worker to inform, educate, and counsel women and couples on HTSP and on the contraceptive options that are available to them. It is important to reiterate, however, that women and couples must understand that they can freely choose whether or not to use a contraceptive method, and that they can freely decide which method they would like to use. Counseling on HTSP can occur at many different times, including before a young woman has had a child, while a woman is pregnant, after a woman has given birth, and during child health visits.

6. **Ask participants if they have any questions.**

Activity 4-2: Review contraceptive options, HTSP, and counseling for young married women and FTPs

Time: 45 minutes

Methodology: Game

The trainer should:

1. **Divide participants into 2–3 teams.**

2. **Give each team a different colored piece of paper. This piece of paper will be used by the team leader to signal that their team has an answer.**

3. **Ask each of the questions below, one at a time using the eight Review Game Slides. Each team should talk amongst themselves to come up with their answer and *come to an agreement about their collective answer*. When the team has reached consensus about an answer, the team leader should raise the colored piece of paper. The team that raises the paper first has the opportunity to share their answer. If they do not get it right, then the next team to raise their paper can share their answer. The team gets one point for each correct answer.**

4. **The team with the most points at the end wins a small prize (e.g., candy).**

5. **When the game is over, the trainer should review the questions once again, this time going into more detail about the answers using the content below.**

Contraception for young women and FTPs and their partners review game

Question 1: **Which contraceptive methods are contraindicated for young women under age 25 who have *not* had children?**

Answer 1: Nearly all contraceptive methods are safe for women of all ages. This includes pills, injectables, implants, IUDs, condoms, and more. While age is not a clinical contraindication for any method, sterilization is the only method that is considered contraindicated for most young women due to their stage in life and the permanent nature of this method. ***All clients should be told that only male or female condoms alone or condoms used with another method (dual method use) offer protection from both unintended pregnancy and STIs, including HIV.***

Question 2: **Which contraceptive methods can be used while a woman is breastfeeding?**

Answer 2: A woman is only preventing pregnancy through breastfeeding if the baby is less than 6 months old, the baby is exclusively breastfed (no other food or liquid is given to the baby, not even water), and the woman's monthly bleeding has not returned. A woman/couple can use the mini-pill (progestin-only pills), implants, IUDs, and male and female condoms during the postpartum period and while breastfeeding. The IUD can be inserted within 48 hours postpartum. After the 48 hour postpartum window, delay insertion until 4 weeks postpartum.

Progestin-only pills and implants can be used immediately postpartum in breastfeeding women. Injectable contraceptives can be used by breastfeeding women from 6 weeks after childbirth.

Question 3: **When can a community worker discuss contraception and HTSP with a young married woman or first-time parent.**

Answer 3**:**

- During the prenatal period
- In the postpartum period
- During visits to monitor infant health

Counseling on the importance of spacing births should begin when the woman is pregnant. If a woman wants to space her next pregnancy, she can select a contraceptive method at this time to begin using during the postpartum period. Visits during the postpartum period and visits to monitor infant health are other good opportunities to provide counseling on HTSP and contraception.

Question 4: **Where should a community worker refer a young woman who wants to use contraception?**

Answer 5: If the young woman wants a method that is available through community-based distribution, the community worker can find a community distributor to provide the woman with contraception. If the young woman wants a wider variety of methods, including long-acting contraceptives, the community worker should refer the young woman to the nearest health center and accompany the woman to the facility.

Session 5: Counseling Young Married Women and FTPs, and their Key Influencers

Objectives of the session:

1. Identify the key principles of counseling young married women and FTPs.
2. Explain special considerations for confidentiality and privacy when counseling young married women and FTPs.
3. Practice counseling young married women and FTPs on HTSP and contraception.
4. Practice counseling husbands, mothers-in-law, and other key influencers on fertility decisions.

Before the training, the trainer should:

- Review the training material.
- Review **Slides 5-1, 5-2, 5-3**.
- Make enough copies of **Participant Handouts 4, 5, and 6** for all participants.

Total session time: 5 hours

Activity 5-1: Identify the key approaches for counseling young married women and FTPs

Time: 45 minutes

Methodology: Case study and group discussion

The trainer should:

1. **Introduce the session by reading out loud the content below:**

As a community worker conducting home visits to young married women, first-time parents, and their families, you will encounter many different situations. Each time you visit a home it might be different. It will be up to you to consider the best way to approach the situation, considering the relationships in the home. It may be most appropriate to begin by talking with the mother-in-law and the husband/partner and then return on another visit to counsel the young women. It may be appropriate to counsel the man and woman together, but remember that the young woman has the right to be seen on her own, and is allowed make choices about her reproductive health without her partner's consent. There might also be different members of the family that you would like to counsel.

The way in which you communicate with people impacts what they are willing and able to learn from you. If you are speaking to a young married woman and you do not think she should be using contraception, this will come across in your actions, in your tone of voice, and in your body language. The counseling skills and principles you learned in your previous training are all relevant to young women, their partners, and other key influencers in their lives. Building on what you learned in your previous training, we will now consider one counseling scenario. Please write down what the community worker does well and does not do well during the home visit.

2. **Read aloud the following story. Tell participants to write down what Salimatou does well and what she doesn't do very well.**

Salimatou, a community worker, is visiting the home of a young woman named Mariam. Mariam is 19 years old and has been married to Karim for one and a half years. They have a 9-month-old baby and Mariam is a first-time mother. When Salimatou arrives at the home, she immediately looks for Mariam. She greets the other people she sees in the compound, but she does not talk to any of the other wives of Karim or the parents of Karim. When Salimatou finds Mariam, Karim is near her. Salimatou asks Karim to leave since she needs to talk to Mariam about things that are for women only. Karim is suspicious. Once Karim leaves, Salimatou checks to make sure there is no one else around and they have privacy. She sits in front of Mariam and looks at her very kindly. She asks Mariam questions about her health and the health of the baby. Salimatou asks Mariam questions about her desires to have another baby. When Mariam says that she thinks that it is time for her to become pregnant again, Salimatou tells her sternly and loudly that dropping out of school so early must have made her a stupid girl and that she must wait at least 2 years after giving birth before becoming pregnant again. Mariam looks frightened, she looks around and whispers to Salimatou

that it is Karim and his mother who are saying it is near the time for her to become pregnant again. Salimatou tells Mariam that she should just ignore those people and go get the injectable at the clinic, because that is the best method. Mariam has many concerns: how can she ignore her husband and mother-in-law? What will happen if she does not produce a child right away, especially since her first baby is a girl? Why is the injectable the best method? Mariam does not like the idea of a needle in her arm. But, Salimatou has 2 more houses to visit that day and so she tells Mariam she has to go. Salimatou tells Mariam that she is happy she decided to use a method and wishes her well. Salimatou leaves the compound without talking with Karim or his mother.

3. Ask the participants the following questions. Supplement with the answers below as needed.

What did Salimatou, the community worker, do well?

Possible answers might include:

- Salimatou checks to be sure they have privacy before asking Mariam sensitive questions.
- Salimatou greeted Mariam warmly.
- Salimatou sat in front of Mariam, at eye-level (not above her).
- Salimatou asked Mariam open-ended question about her health and the health of her child.
- Salimatou asks Mariam about her desires to have a baby.
- Salimatou gives Mariam accurate information about how long she should wait between a birth and pregnancy.

What did Salimatou do poorly?

Possible answers might include:

- Salimatou does not take time to talk with the other members of the family to build a rapport and trust.
- Salimatou does not explain to the family what she is doing there or ask to speak with Karim first.
- Salimatou spoke very badly to Mariam when she said she wanted to have another child soon. She was rude, harsh, disrespectful, and judgmental.
- Salimatou did not consider the importance of the pressure that Mariam faces from her mother-in-law and husband. Salimatou did not give Mariam any opportunity to discuss the pressure she feels or provide Mariam with ways to talk about fertility desires with her family.
- Salimatou did not spend time to talk to Mariam more about the benefits of healthy timing and spacing of pregnancies or about the different methods of contraception that she could use.
- Salimatou did not spend time to ask Mariam if she had any questions.
- Salimatou did not give Mariam clear information about where she should go for contraception or offer to accompany her.
- Salimatou did not spend time to talk with the other members of the family before leaving.

4. Present the content below:

As community workers who are going to be counseling young married women and first-time parents, it is important to learn from the mistakes that Salimatou made and build on the good things she did. It is your obligation to protect the privacy and confidentiality of all clients and to treat them with respect and dignity. However, when conducting home visits, it is very important to build trust and understanding with key influencers, such as the woman's husband, co-wives, and parents-in-law. If a first-time mother is living with her parents, they may also act as key influencers with regards to her reproductive decisions. Forming a relationship with the key influencers may require many visits to talk with the family before speaking with the young woman alone. You may also consider counseling both partners at the same time, but this will depend first on whether the young woman feels comfortable and agrees to this. It will also depend on your relationship with the family and the dynamics between the husband and the wife.

5. Ask participants to brainstorm a list of the good counseling techniques that they have learned through previous SRH training. After they have finished brainstorming, supplement their answers with the content below using Slides 5-1, 5-2, and 5-3.

Supplemental answers considerations for counseling:

- Use home visits to establish trust with the extended family and talk to different people about the importance of HTSP.
- When counseling the individual young woman, ensure that there is privacy—do not ask her personal questions with other people around.
- Sit at eye-level with the client.
- Greet the client warmly.
- Maintain the confidentiality of the young women and their families. Do not tell other people about their experiences and decisions.
- Ask open-ended questions about her wellbeing and the wellbeing of her child/children (if she has any).
- Show respect for the relationship between the couple, by asking about the husband/partner's opinions.
- Do not do all the talking.
- Emphasize the importance of the health of the family and the other benefits of HTSP, such as greater economic stability and improved nutrition.
- Be aware of yourself, what you are feeling, and what you are giving to the other person. Do not let your own values and biases prevent you from counseling the young woman accurately and comprehensively.
- Provide accurate information, never give wrong information, and if you do not know something, say you do not know (and will find out).
- Use simple words.
- Encourage people to ask questions.
- Use visual aids (e.g., a picture, flipchart) if available or show a person how to do a task (e.g., putting on a condom) as you explain.
- Listen carefully to what is said and repeat back to make sure you have understood correctly.

Activity 5-2: Describe special considerations for confidentiality and privacy

Time: 45 minutes

Methodology: Case study and group discussion

The trainer should:

1. **Present the content:**

While working with young women and their partners, as well as key influencers in the household, it is important to think about how you will maintain privacy and confidentiality of young women and of the couple. Young people have said that privacy and confidentiality is very important to them when it comes to sexual and reproductive health services and it is important to establishing a trusting relationship between the community workers and young women. But when you do home visits, this can be difficult. For this activity, I will read aloud two scenarios. For each scenario, please consider what you would do in order to maintain privacy and confidentiality. Let's be creative.

2. **Read aloud the two scenarios below, one at a time. After reading each scenario, ask participants what they would do in order to maintain privacy and confidentiality. Allow participants to discuss different ways to handle the situation. There is not one right answer.**

Scenario 1

You are a community worker. You are on your second visit to a young woman named Hawa. Hawa is 17 years old and she is the second wife of Oumar. On your first visit you met with Oumar and his mother (Hawa's mother-in-law). They were a little bit reluctant to talk about contraception, but they agreed it was okay for you to talk with Hawa since her child is only 1 year old and Hawa is still very young. On the visit today you spoke with Hawa. Hawa was happy to learn about HTSP and agreed that she would like to go to the health center for a method of contraception. She asked you to accompany her to the health center tomorrow. On your way out of the compound, you see Hawa's mother-in-law. You stop under the tree outside to talk with the mother-in-law. The mother-in-law knows you talked to Hawa and is very curious. She starts asking you many questions and wants you to tell her if Hawa agreed to start using a contraceptive method. What do you say? How do you handle the situation?

Scenario 2:

It is your third time visiting a young woman named Korotimi and her new husband, Ousmane. They have not had a child yet and you have been talking with them about delaying the first birth. Today, Ousmane's sister, father, mother, and aunt are all sitting under the tree with the young woman. You suggest that you could go talk with Korotimi somewhere more private, but Ousmane's father objects. What do you do?

3. Conclude by reading aloud the following content:

It is important to respect the young women who you are working with and ask them what their wishes for privacy and confidentiality are. If they do not want mothers-in-law or other community/family members or even their partner to know, then it is your duty to respect their desires. However, it is important to maintain the trust of the family. You can use some of the creative solutions we have discussed today to help navigate these different demands.

Activity 5-3: Practice counseling young married women and first-time parents

Time: 2 hours

Methodology: Role play

The trainer should:

1. **Introduce the role play exercise.**
2. Distribute **Participant Handout 4: Scenarios for Counseling Role Plays** and **Participant Handout 5: Observation Checklist for Counseling Role Plays.**
3. **Review both handouts with the group, orienting them on the three scenarios in Participant Handout 4 and on the observation checklist in Participant Handout 5.**
4. **Ask participants to form groups of three people. For each set of three, ask participants to decide who will be the community worker, who will be the client, and who will be the observer for the first role play.**
5. **Ask each set of participants to select one of the three scenarios in Participant Handout 4**.
6. **Ask participants to act out the scenarios using the counseling skills we've discussed. One person should act as the community worker, another as the client, and the third as the observer. After they have acted out the first scenario, the observer should provide his/her feedback using Participant Handout 5 to guide his/her observations.**

   Note to trainer: You may circulate and observe the role plays. If the "community worker" needs assistance, you may use the suggestions included below under each scenario as prompts ("Topics that the community worker can cover in the counseling").
7. **Each group should decide which language they are most comfortable using for the scenarios—ideally, this should reflect the language that they are most likely to use with clients.**
8. **Now ask the participants to select another scenario and rotate roles so that the person who was the community worker is now the young married woman, the person who was the young married woman is now the observer, and the person who was the observer is now the community worker. Repeat step 6.**
9. **Then ask the participants to select a third scenario and switch roles so that each member plays the role they have not played yet. Repeat step 6.**
10. **Bring the group back together and facilitate a discussion using the questions below. Ask respondents to refer to their observation checklists to facilitate discussion.**

- When you were in the role of the young married woman, what behaviors did you notice that were not comforting? What behaviors were comforting?
- When you were in the community worker role, what behaviors did you find came naturally to you? What behaviors were not as natural or were more difficult?
- When you were the observer, what were some of the positive counseling skills you observed? What were some ways that the providers could improve?

Scenarios: Role Plays for Counseling Young Women (also Handout 4)

Scenario 1: The community worker is conducting a home visit to a young married woman of 16. She is recently married and has not had a child yet. Her mother-in-law and the sisters of the husband are already talking about how she must be sterile since she is not yet pregnant and it has been five months since she married.

Topics that the community worker can cover in the counseling: Importance of delaying the first birth until she is at least 18 years old for the health of the mother and the baby; methods of contraception she could use to delay the first birth; use of different methods; characteristics of different contraceptive methods; opportunities she might have for school or work if she delays becoming pregnant; strategies to deal with the pressure she is facing from her husband, mother-in-law or sisters-in-law; strategies to talk to her husband about her desire to delay a pregnancy.

Scenario 2: The community worker is conducting a home visit with a 19-year-old young woman. The young woman just gave birth to her first child. She is nervous. Her labor was very difficult, and she does not want to become pregnant again right away. She does not know how long she should wait to become pregnant and she has not heard much about contraception. Her husband has two other wives, and he is happy that the young woman's newborn baby is a boy. The young woman thinks her husband might be open to supporting her to use contraception, but she has never tried to talk to him about it.

Topics that the community worker can cover in the counseling: Importance of waiting at least two years before becoming pregnant again and why that is important for the health of the mother and the baby; methods of contraception she could use to space the next pregnancy; use of different contraceptive methods; characteristics of different contraceptive methods; strategies to talk to her husband about her desire to space her next pregnancy; strategies to deal with the co-wives and other pressures she might feel to have a child very soon.

Scenario 3: The community worker is conducting a home visit with a 22-year-old young woman. She has three children and the community worker can see that they are very malnourished. When the community worker asks the young woman if she is thinking of having another child soon, the young woman says that it depends on God. The young woman has never heard of contraception. The community worker knows the young woman's mother-in-law, and the mother-in-law is eager to have many grandchildren.

Topics that the community worker can cover in the counseling: Importance of waiting at least two years before trying to becoming pregnant again; why spacing is important for the health of the mother and the baby; why spacing the next pregnancy will help with the wellbeing of her children; methods of contraception she could use to space the next pregnancy; use of different contraceptive

methods; characteristics of different contraceptive methods; strategies to talk to her husband about her desire to space her next pregnancy; strategies to deal with her mother-in-law and other pressures she might feel to have a child very soon.

Activity 5-4: Practice counseling husbands, partners, mothers-in-law, and other key influencers

Time: 2 hours

Methodology: Role play

The trainer should:

1. **Present the content below:**

   Counseling young married women and first-time parents is an important skill, but community workers also need to work closely with the people who have influence and power over young women and FTPs' reproductive health and lives. In this activity, we will do another variation of a role play exercise to practice our skills with the different key influencers. This time, each group will only act out one scenario in front of the whole group. We will all be the observers of each other and have time after each skit/drama to provide feedback.

2. **Distribute Participant Handout 6: Scenarios for key influencer role plays. Read the four scenarios aloud to the group (also found below).**

3. **Ask participants to form four groups, one for each scenario. Some scenarios require more people than others, so group people accordingly. Assign each group one of the scenarios. If there are more people in a group than characters in the scenario, encourage the group to invent additional characters to ensure there is a role for each group member in the drama.**

4. **Give the participants 15 minutes to prepare how they will act out (role play) the counseling session.**

5. **Once all the groups are ready, have them take turns acting out the counseling scenarios for the rest of the group.**

6. **After each role play, ask the audience:**

   - What did the community worker do well in the role play?
   - What else could the community worker have done to make the counseling session more effective?

7. **After all the groups have done their role plays, bring the group back together and facilitate a discussion using the questions below.**

   - What were some of the behaviors and strategies used by the community workers that seemed to be most effective in the different role plays?
   - What strategies do you think are particularly effective for addressing HTSP and contraception with in-laws?

- What strategies do you think are particularly effective for addressing HTSP and contraception with religious leaders?
- What strategies do you think are particularly effective for addressing HTSP and contraception with husbands and partners of young women?
- How do you think community workers should handle a home visit when many people in the family are gathered together? What worked well in the role play? What else might work well?

8. Conclude the activity by reading aloud the content below:

Your role as a community worker is to help create a supportive environment for young women to practice HTSP. In order to do this, you will counsel and conduct discussions with many different key influencers, like religious leaders, husbands/partners, mothers-in-law, sisters-in-law, and more. As we saw in this activity, there are many things to take into consideration when conducting a counseling session. For example, when counseling husbands/partners in a group setting, it may be useful to gather them by age or status so that they feel comfortable with one another. It might also be helpful to work with religious leaders and then have the religious leaders counsel the husbands and partners. When counseling a young woman or a couple, it is important to ensure their privacy and confidentiality. If other people walk in the room or want to join the conversation, it is important to be sure not to tell other people anything the couple or the young woman might have said to you. You are a member of this community and you know how to deal with different people. It will be important to consider the different circumstances of each situation and do your best to maintain respect, privacy, and confidentiality throughout the counseling.

Scenarios for Key Influencer Role Plays (also Handout 6)

Scenario 1 (4 people): The community worker is counseling a mother-in-law and sisters-in-law of a young married woman whose first child is 1 year old. They want her to have another child soon.
Characters: Community worker, mother-in-law, 2 sisters-in-law.

Scenario 2 (4 people): A small group of husbands are gathered with a male community worker. The husbands have all recently married young women who have not yet had a child. It has only been a few months, but they are complaining already that they have chosen bad women.
Characters: Community worker, 3 husbands.

Scenario 3 (4-6 people): The community worker is holding a small group discussion with a group of religious leaders. They are not necessarily against all family planning, but they do not believe it is a good thing for young women.
Characters: Community worker, 3-5 religious leaders.

Scenario 4 (5 people): The community worker is counseling a married man and his young wife (20 years old) on HTSP. The man's mother and one of the co-wives have also walked into the room and have a lot of things to say, creating a chaotic situation that the community worker has to manage.
Characters: Community worker, husband, young wife, mother-in-law, co-wife.

Session 6: Review and Conclusion

Objective of the session:

1. Review key learnings from the training module.

Before the training, the trainer should:

- Review the material.
- Obtain 1 piece of blank paper per participant.
- Obtain tape.

Total session time: 45 minutes

Activity 6-1: Review game

Time: 45 minutes

Methodology: Game

The trainer should:

1. **Ask participants to spend a couple minutes thinking about the entire training curriculum and developing one review question. The review questions should be on issues that the participants feel are important for their classmates to remember from the training. Ask participants to write their question on a piece of paper.**

2. **Collect the questions and wrap them around one another, making a large ball of wadded paper. It should resemble a cabbage. It often helps to use tape to hold the "cabbage" together.**

3. **When you have made the "cabbage" of paper questions, ask the participants to stand in a closed circle. Tell them you will be toss the cabbage to a participant. After they catch it, they must peel back a layer of the cabbage and answer the question written on the piece of paper. If they do not know the answer, they may ask a colleague for help. After the question has been correctly answered, the participant throws the cabbage to someone who has not answered a question yet.**

4. **The cabbage should be tossed until the last question has been answered.**

   Note to trainer: It can be fun to make the very center of the cabbage a note from the trainer that says, "Good job, team! You're finished!"

5. **Thank participants for their participation in the session, ask for any remaining questions, and close the day.**

Annex 1: Participant Handouts

Participant Handout 1: Training Schedule

Day One	
Time	**Session and activities**
9:00-9:15	Welcome and introductions
9:15-9:30	Session 1: Introduction to the module
9:30-10:30	Session 2: Understanding the needs of young married women and FTPs, and the challenges that they face Activity 2-1
10:30-11:00	Break
11:00-12:30	Session 2: Understanding the needs of young married women and FTPs, and the challenges that they face Activity 2-2 and Activity 2-3
12:30-1:30	Lunch
1:30-3:00	Session 3: Attitudes and values related to young married women and FTPs regarding fertility and contraception
3:00-3:15	Break
3:15-4:00	Session 4: Healthy timing and spacing of pregnancy Activity 4-1
4:00 – 4.45	Session 4: Healthy timing and spacing of pregnancy Activity 4-2
4:45-5:15	Daily wrap-up
Day Two	
Time	**Session and activities**
9:00-9:15	Welcome and summary of the previous day, review of 2nd day
9:15-10:00	Session 5: Counseling young married women and FTPs, and their key influencers Activity 5-1
10:00-10:45	Session 5: Counseling young married women and FTPs, and their key influencers Activity 5-2
10:45-11:00	Break
11:00-1:00	Session 5: Counseling young married women and FTPs, and their key influencers Activity 5-3
1:00-2:00	Lunch
2:00-4:00	Session 5: Counseling young married women and FTPs, and their key influencers Activity 5-4
4:00-4:30	Session 6: Review and Conclusion

Participant Handout 2: Case Study – Fatimata

My name is Fatimata. I am 17 years old. I have a baby girl who is 1 year old. I have been married to my husband for two years. I am the youngest of my husband's three wives. I love my baby girl, but I worry about her a lot because it seems like she is always sick. My husband's mother is always asking when we will have our next child. She says that the baby will start running everywhere soon, so it is time.

I know I need to have another baby, especially because my first baby is a girl. But, I know that having another baby soon will be very hard for me and my little girl, since she has been so sick. It will mean that I will have to make the small amount of food we have stretch even further.

I heard you could get a shot to avoid having a baby for three months, but I don't know anything about it. There are some community health workers working in my community, but they are older women who are friends with my mother-in-law, and I know my husband and mother-in-law would disapprove if they knew I wanted to learn more about the medicine to prevent pregnancy. I don't have any friends to talk to about this. I hardly even leave the compound. All my friends from school are also married and live far away.

I was scared, but I decided to try to go to the nearest health center. I hoped that I wouldn't see people I knew there. I told my husband and mother-in-law that the baby was sick and walked the 10 km to the nearest health center.

I went to the health center early in the morning because I needed to go back home and do household chores before it became too late in the day. When I arrived, there were several women waiting outside with many children. They kept looking at me.

The health center staff was late to arrive. I waited for an hour. When the facility opened, I got up enough courage to speak to the woman behind the table with a sign saying "Reception." She asked me why I was at the clinic when my baby wasn't sick. When I explained that I wanted to talk with the nurse about family planning, she made a disapproving face and just pointed to the consultation waiting area.

I waited for two hours near the family planning room. I hadn't eaten anything and my baby started to cry. I felt that all the older women were staring at me. One of the women recognized me. She is a friend of my mother-in-law and asked me why I was there since the family planning services are for older women who are ready to stop having children, not a young woman like myself who should have another child while I'm still young.

I was finally called in to speak with one of the nurses. When I went into the consultation room, the nurse looked angry. She asked me why I was here. I told her that I didn't want to be pregnant so soon after my last baby and I had heard there was some kind of shot I could get. She asked if my husband had given me permission to be there. I looked down and told her that I hadn't told him why I was coming. The nurse told me that I had better not use family planning since my husband was certain to find another wife if I didn't have another baby soon, especially since my first baby was a girl. She said I should have all my babies now while I'm young.

I explained that my baby was sickly and it wouldn't be good for us to have another child so soon. The nurse finally said that it is ok for me to use a method and said I should use the three-month injectable, she didn't mention any other method options. I waited for another hour before she gave me the injection, and then the nurse called me in a very loud voice "Fatimata, your injection is ready." I could feel the eyes of the other women in the waiting room staring at me, including that friend of my mother-in-law. I got my injection and left the clinic very embarrassed and worried.

Participant Handout 3: Healthy Timing and Spacing of Pregnancy

The handout begins on the following page and is available online in French and English:

https://www.k4health.org/toolkits/htsp/htsp-101-everything-you-want-know-about-healthy-timing-and-spacing-pregnancy

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[1]:

- *<u>After a live birth</u>, 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.*
- *<u>After a miscarriage or induced abortion</u>, 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 make an informed decision about the delay of first pregnancy and the spacing or limiting of subsequent pregnancies to achieve the healthiest outcomes for women, newborns, infants and children, within the context of free and informed contraceptive choice**,** taking into account fertility intentions and desired family size, as well as the social and cultural contexts.

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)

*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.

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.[2]

- *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.[3]

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.[4] 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.[5]

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%.[6] 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.[7]

- *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.[8] 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,[*] wait at least 24 months, but not more than 5 years,[†] before trying to become pregnant again.
- 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.

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

[*]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.

[†]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, 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.[9] 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 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[†], 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[10] 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 knowledge using a tracking matrix. ESD is also developing a list of common HTSP indicators.

[†]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.

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.

Prepared by May Post, Extending Service Delivery Project.

Based on the ESD HTSP Strategy, available at www.esdproj.org.

Please contact esdmail@esdproj.org for more information.

[1] Report of a WHO Technical Consultation on Birth Spacing. World Health Organization, 2006.
[2] 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.
[3] 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.
[4] Married Adolescents: No Place for Safety. WHO and UN Population Fund: WHO, 2006.
[5] Shane Barbara (1997), cited in *State of the World's Mothers 2006: Saving the Lives of Mothers and Newborns*. Save the Children, 2006.
[6] 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.
[7] 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.
[8] 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.
[9] 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.
[10] Jansen, W. and L. Cobb, USAID Birth Spacing Programmatic Review: An Assessment of Country-Level.

Participant Handout 4: Scenarios for Counseling Role Plays

Scenario 1: The community worker is conducting a home visit to a young married woman of 16. She is recently married and has not had a child yet. Her mother-in-law and the sisters of the husband are already talking about how she must be sterile since she is not yet pregnant and it has been five months since she married.

Scenario 2: The community worker is conducting a home visit with a 19-year-old young woman. The young woman just gave birth to her first child. She is nervous. Her labor was very difficult, and she does not want to become pregnant again right away. She does not know how long she should wait to become pregnant and she has not heard much about contraception. Her husband has two other wives, and he is happy that the young woman's newborn baby is a boy. The young woman thinks her husband might be open to supporting her to use contraception, but she has never tried to talk to him about it.

Scenario 3: The community worker is conducting a home visit with a 22-year-old young woman. She has three children and the community worker can see that they are very malnourished. When the community worker asks the young woman if she is thinking of having another child soon, the young woman says that it depends on God. The young woman has never heard of contraception. The community worker knows the young woman's mother-in-law, and the mother-in-law is eager to have many grandchildren.

Participant Handout 5: Observation Checklist for Counseling Role Play

TASK OR ACTION	YES	NO	COMMENTS
Counselor assures confidentiality?			
Friendly/welcoming/smiling/respectful?			
Not judgmental or condescending?			
Listens attentively/nods head to encourage and acknowledge client's responses?			
Uses open-ended questions (i.e., not yes/no questions)?			
Uses non-technical terms and language the patient can understand?			
Counsels the client using the HTSP messages?			
Asks the client about pressures she may be feeling to have a baby and discusses how to deal with those pressures?			
Listens to client's responses closely and patiently?			
Provides encouragement and reassurance?			
Counsels the client on a full range of contraceptive methods, including long-acting methods (i.e., does not just offer one or two methods)?			
Prepares the client to use the method she selects effectively, including thorough discussion of side effects and what the client can expect?			
Responds to client's non-verbal communication?			
Is non-directive (i.e., does not tell the client what she has to do or not do)?			
Asks the client if she has any questions?			
Answers client's questions?			
Summarizes and ensures a common understanding of the discussion?			
Provides the client with a referral to the nearest health facility and offers to accompany the client?			

Please record any additional observations/comments for feedback to the participants:

Participant Handout 6: Scenarios for Key Influencer Role Plays

Scenario 1 (4 people): The community worker is counseling a mother-in-law and sisters-in-law of a young married woman whose first child is 1 year old. They want her to have another child soon.
Characters: Community worker, mother-in-law, 2 sisters-in-law.

Scenario 2 (4 people): A small group of husbands are gathered with a male community worker. The husbands have all recently married young women who have not yet had a child. It has only been a few months, but they are complaining already that they have chosen bad women.
Characters: Community worker, 3 husbands.

Scenario 3 (4-6 people): The community worker is holding a small group discussion with a group of religious leaders. They are not necessarily against all family planning, but they do not believe it is a good thing for young women.
Characters: Community worker, 3-5 religious leaders.

Scenario 4 (5 people): The community worker is counseling a married man and his young wife (20 years old) on HTSP. The man's mother and one of the co-wives have also walked into the room and have a lot of things to say, creating a chaotic situation that the community worker has to manage.
Characters: Community worker, husband, young wife, mother-in-law, co-wife.

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