For more information on Healthy Timing and Spacing of Pregnancy, visit the Extending Service Delivery (ESD) project website at:
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Bayer Schering Pharma AG
Social Health Care Programs
Family Planning
13342 Berlin, Germany

www.bayerscheringpharma.de

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What should you advise your patients about the right time to get pregnant?

A Health Practitioner's Guide to Healthy Timing and Spacing of Pregnancy

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Healthy Timing and Spacing of Pregnancy

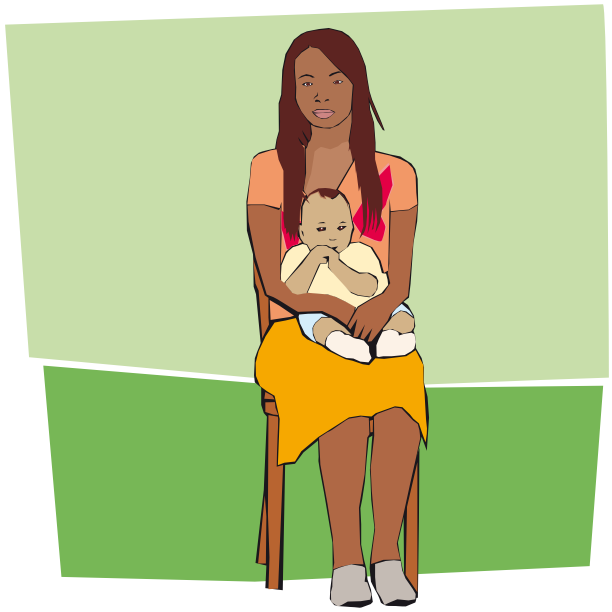
What is the Healthy Timing and Spacing of Pregnancy initiative?

It is a public health initiative supported by the U.S. Agency for International Development (USAID) to protect the health of mothers and their children. The findings and guidance under this initiative are based upon USAID-funded research and the recommendations of 37 technical experts to the World Health Organization.

Bayer Schering Pharma, the world leader in safe contraception methods, is pleased to support and promote Healthy Timing and Spacing of Pregnancy.

This guide for health practitioners:

- Provides the latest scientific data supporting the healthy timing and spacing of pregnancy, and
- Answers key questions about how to advise patients on the healthiest time to become pregnant.



Depending on when your patient decides to get pregnant, it will affect her life as well as the lives of her children.

What is Healthy Timing and Spacing of Pregnancy?

It is a health intervention to help girls, 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.*

It is an aspect of family planning that is associated with **healthy fertility** and **desired family size.**

And it is based on strong scientific evidence indicating the health benefits of pregnancy spacing:

Healthy Timing and Spacing of Pregnancy after a live birth or after a miscarriage or induced abortion has these health benefits:

For children:	For mothers:
Lower risk for perinatal death	Lower risk of maternal death
Lower risk for preterm birth	Lower risk for miscarriage
Lower risk for low birth weight	Lower risk of pre-eclampsia
Lower risk for small gestational age	Lower incidence of induced abortion
Lower risk for neonatal death	

Healthy Timing and Spacing of Pregnancy

What should you advise women who are planning to have another child?

For the health of mother and baby:
Wait at least 24 months after the last live birth before trying to become pregnant again* – but not more than 5 years.

And consider using a family planning method of your choice during that time.

*This is the recommendation that 37 experts conveyed to the World Health Organization (WHO) in a 2006 technical consultation report.

Why advise waiting for 24 months to become pregnant again?

1. A 24-month, birth-to-pregnancy interval is associated with reduced risks of multiple adverse health outcomes for mothers, newborns, and infants. The 24-month interval also supports the WHO recommendation to breastfeed for two years.

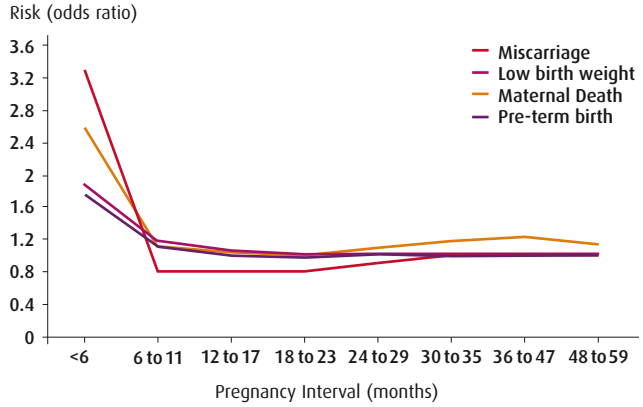
2. A 24-month, birth-to-pregnancy interval is associated with reduced risks of newborn and infant mortality. Data from many developing countries in Africa, Asia, Latin America, and the Middle East show a sharp decline in mortality risk for newborns and infants with birth-to-pregnancy intervals of 24 months.

Increased risks when pregnancy occurs 6 months after a live birth

Adverse Outcome	Increased Risk
Miscarriage	230%
Newborn Death (<9 mos.)	170%
Maternal Death	150%
Preterm Birth	70%
Stillborn	60%
Low Birth Weight	60%

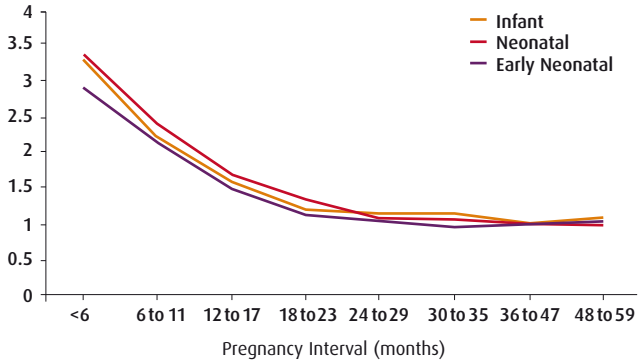
Sources: Conde-Agudelo, et al, 2000, 2005, 2006; Da Vanzo, et al, 2007

Figure1. Birth-to Pregnancy Interval and Relative Risk for Adverse Maternal and Pregnancy Outcomes



Sources: Conde-Agudelo 2005 and DaVanzo et al 2007

Figure2. Birth to Pregnancy Interval and Relative Risk for Neonatal and Infant Mortality



Sources: Rutstein 2005

Healthy Timing and Spacing of Pregnancy

What should you advise a woman about getting pregnant again after a miscarriage or an induced abortion?

For the health of mother and baby:
Wait at **least 6 months** before trying to become pregnant again*.

And consider using a **family planning method** of your choice during that time.

*This is the recommendation that 37 experts conveyed to the World Health Organization (WHO) in a 2006 technical consultation report.

Why advise waiting 6 months before trying to become pregnant after a miscarriage or abortion?

A 6-month interval has been shown to protect a pregnant woman's health and the health of her baby.

Women delivering singleton infants after becoming pregnant less than 6 months after a miscarriage or abortion had greater risk for adverse maternal and perinatal outcomes than women who waited more than 6 months. These adverse outcomes include preterm birth, small size for gestational age, low birth weight, maternal anemia, and premature rupture of membranes.

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, 2005

What should you advise an adolescent about the healthiest timing for becoming a new mother?

Why advise delaying pregnancy until age 18?

Because delaying until the age 18 protects the life and health of a teen mother and her baby:

- Compared to older women, girls in their teens are twice as likely to die from pregnancy and childbirth-related causes.
- Their babies face a 50 percent higher risk of dying before age 1 than babies born to women in their 20s.

The annual burden of disease report estimates that 14 million adolescent pregnancies happen every year. About 60 percent of married adolescents report that their first birth was either mistimed or unintended.

For the health of mother and baby:
Wait until you are **at least 18 years** old before trying to become pregnant.

And consider using a **family planning method** of your choice during that time.

What are the short-acting and long-acting modern contraceptive methods your patients may wish to consider?

Progestin-Only Oral Contraceptive Pills (POPs)

POPs, also called "mini pills," contain very low doses of progestin, a synthetic hormone that acts like the natural hormone progesterone, preventing ovulation. Must be taken daily. Effective (as commonly used, 3-10 pregnancies per 1000 women using POPs during the first year).

Who can use:
Nearly all women, including breastfeeding women (six-weeks postpartum), non-breastfeeding women, HIV+ women, and women who cannot use methods with estrogen.

Who should not use:
See product contraindications.

Combined Oral Contraceptive Pills (COCs)

COCs contain the hormones estrogen and progesterone, which prevent ovulation. Must be taken daily. Effective (as commonly used, about 8 pregnancies per 1000 women using COCs during the first year).

Who can use:
Nearly all women, including HIV+ women.

Who should not use:
Women who are breastfeeding (less than six month post-partum). See product contraindications.

Benefits	Limitations
All Contracepive Pills-Both COCs and POPs »» Short-acting method »» Can be used by HIV+ women, including those on ARVs »» Highly effective, reversible, easy to use »» Controlled by the woman »» Can be stopped at any time without a provider's help »» Pelvic exam not required before use and trained non-medical staff can provide it	**All Contracepive Pills-Both COCs and POPs** »» Does not protect against STIs & HIV »» Client-dependent; must be taken every day »» Requires regular/ dependable supply »» May cause side effects such as: headaches, dizziness, breast tenderness, abdominal pain and nausea »» May cause changes in bleeding patterns »» HIV+ women including those on ARVs should also use condoms to most effectively prevent pregnancy and HIV transmission
COCs only »» Regulates the menstrual cycle »» Reduces menstrual flow (which may be useful to anemic women) »» Decreases the risk of ovarian and endometrial cancer, benign breast disease, and incidence of acne	**COCs only** »» Should not be used by breastfeeding women <6 months postpartum »» Risk of developing cardiovascular disease in women over 35 years of age who smoke, have diabetes, or high blood pressure
POPs only »» Can be used while breastfeeding, as early as six weeks postpartum »» Can be used by women who cannot use methods with estrogen »» Can be used by smokers of any age	**POPs only** »» Managing bleeding changes may require patient counseling

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

What are the short-acting and long-acting modern contraceptive methods your patients may wish to consider?

Injectable Contraceptive (Progestin Only):

Progestin-only injectable contraceptives contain the hormone progesterone (DMPA – Depot Medroxyprogesterone Acetate or Norethisterone enastak), which suppresses ovulation. It is given once every 12 weeks. Effective (as commonly used, about 3 pregnancies per 1000 women using injectable contraception during first year).

Who can use Injectables:
Nearly all women, including breastfeeding women (six-weeks postpartum), non-breastfeeding women, HIV+ women, and women who cannot use methods with estrogen.

Who should not use Injectables:
See product contraindications.

Benefits	Limitations
»» Short-acting method »» Rapidly effective (<24 hours) »» Can be used by HIV+ women, including those on ARVs »» Flexible method: can be administered 2 weeks before or after scheduled date »» Can be used by smokers of any age »» Appropriate for women who have just had an abortion or miscarriage; have high blood pressure, blood clotting problems, sickle cell disease »» No daily pill-taking »» No effect on breast milk »» May help prevent iron-deficiency anemia »» Pelvic exam not required before use	»» Does not protect against STIs & HIV. »» Delays return to fertility (half of users experience a 6-9 month delay after discontinuation before becoming pregnant) »» Requires regular injection every 3 months »» May cause loss of bone density »» May cause changes in bleeding patterns »» May cause weight gain and other minor side effects

Source: "Family Planning: A Global Handbook for Providers," WHO and CCP, 2007

Implants

Implants are small plastic rods or capsules that release very low doses of progestin, a synthetic hormone that acts like progesterone, preventing ovulation. Very Effective (less than 1 pregnancy per 1000 women using implants during the first year).

Who can use implants:
Nearly all women, including breastfeeding women (six-weeks postpartum), non-breastfeeding women, HIV+ women, and women who cannot use methods with estrogen.

Who should not use implants:
See product contraindications.

Benefits	Limitations
»» Long-acting method (3-7 years) »» Does not require the user to do anything once inserted »» Can be used by HIV+ women, including those on ARVs »» May help protect against iron-deficiency anemia »» No delay in fertility after removal	»» Does not protect against STIs and HIV »» May cause changes in bleeding patterns »» May cause side effects such as: headaches, abdominal pain, acne, weight change, breast tenderness, dizziness, mood changes and nausea »» Trained provider required for insertion and removal

Source: "Family Planning: A Global Handbook for Providers," WHO and CCP, 2007

What are the short-acting and long-acting modern contraceptive methods your patients may wish to consider?

Intrauterine Contraceptive Device (IUCD)

Copper-releasing IUCDs (Copper T 380A) is a non-hormonal method that causes a chemical change that damages sperm and egg before they can meet. Very effective (less than 1 pregnancy per 1000 women using an IUCD during the first year).

Who can use IUCDs:
Nearly all women, including postpartum* women after 4-6 weeks, and women who cannot use hormonal methods. (*IUDs can be inserted within 48 hours after birth by providers with special training.)

Who should not use IUCDs:
See product contraindications.

Benefits	Limitations
»» Long-acting method (up to 10 years) »» No hormonal side effects with copper-bearing IUCDs »» Does not interfere with breastfeeding »» No delay in return to fertility after removal »» Can be used by smokers of any age »» Appropriate for women who have just had an abortion or miscarriage »» No interactions with any medicines »» May help protect against endometrial cancer »» Significantly reduces risk of ectopic pregnancies »» Does not require user to do anything once IUCD is inserted	»» Does not protect against STIs and HIV »» Requires a trained health care provider to insert and remove »» Can be used by HIV+ women **only when** they are clinically well »» May cause changes in bleeding patterns and cramping »» Pelvic inflammatory disease (PID) may (rarely) occur in women with chlamydia or gonorrhea at the time of IUCD insertion

Source: "Family Planning: A Global Handbook for Providers," WHO and CCP, 2007

Levonorgestrel Intrauterine Releasing Systems (IUS)

Levonorgestrel Intrauterine Releasing Systems (LNG-IUS) is a T-shaped plastic device that steadily releases small amounts of levonorgestrel, suppressing the growth of the uterine lining. Very effective (less than 1 pregnancy per 1000 women using an LNG-IUS during the first year).

Who can use LNG-IUS:
Nearly all women, including breastfeeding women after 4-6 weeks postpartum.

Who should not use LNG-IUS:
See product contraindications.

Benefits	Limitations
»» Long-acting method (up to 5 years) »» No delay in return to fertility after removal »» May reduce menstrual cramps and symptoms of endometriosis including pelvic pain and irregular bleeding »» Helps protect against iron-deficiency anemia »» May help protect against pelvic inflammatory disease (PID)	»» Does not protect against STIs and HIV »» Requires a trained health care provider to insert and remove »» Can be used by HIV+ women **only when** they are clinically well »» May cause changes in bleeding patterns »» May cause ovarian cysts

Source: "Family Planning: A Global Handbook for Providers," WHO and CCP, 2007

Healthy Timing and Spacing of Pregnancy

What are the short-acting and long-acting modern contraceptive methods your patients may wish to consider?

Male and Female Condoms

Condoms are barrier methods that physically prevent sperm from uniting with the ovum to be used during every act of intercourse. Moderately effective (as commonly used, about 15 pregnancies per 1000 women for male condoms and 21 per 1000 for female condoms during the first year).

Condoms are the only contraceptive method that can protect against both pregnancy and STIs, including HIV.

Condoms and another method – or dual method use – should be encouraged for HIV+ clients to prevent pregnancy and disease transmission.

Who can use condoms:
Men and women of any age.

Who should not use:
People allergic to latex (in male condoms only).

These are the most recommended modern family planning methods for women and couples to consider in determining the healthy timing and spacing of pregnancy:

	**Condoms**	These are a few of the Bayer Schering Pharma products that your patients may consider for their family planning needs:
	**Oral contraceptive: Pills**	Microgynon 30 ED FE® Microlut®
	**1 monthly / 3 monthly Injection**	Norigynon® Noristerat®
	**Implants**	Jadelle®
	**Long-term methods: IUS (Intra Uterine Systems)**	Nova T® LNG-IUS

Healthy Timing and Spacing of Pregnancy

Frequently asked questions

How were birth-to-pregnancy intervals determined?

In June 2005, the World Health Organization (WHO) convened a panel of 37 technical experts to review six USAID-sponsored studies on pregnancy spacing. Based on their review of the evidence, the technical experts made two recommendations to WHO, which are included in a 2006 report and policy brief:

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

WHO is reviewing the experts' recommendations and additional scientific analyses it has requested. After this review, WHO may issue further recommendations on pregnancy spacing.

Why is the emphasis on pregnancy spacing?

Qualitative studies conducted by USAID in Pakistan, India, Bolivia and Peru showed that women and couples were interested in knowing the healthiest time to become pregnant rather than when to give birth. HTSP recommendations make it easier for couples to know how long they need to use a contraceptive method of their choice to achieve a healthy pregnancy outcome.

New studies show that pregnancy spacing after miscarriage or abortion is also important to healthy outcomes for mother and baby.

How should health practitioners incorporate HTSP into their overall considerations about a patient's condition?

In making their recommendations to WHO, the 37 technical experts noted that "individuals and couples should consider health risks and benefits along with other circumstances such as their age, fecundity, fertility aspirations, access to health services, child-rearing support, social and economic circumstances, and personal preferences in making choices for the timing of the next pregnancy."

Health practitioners should convey this information to clients to help them make an informed choice about their family planning needs as part of an overall discussion about a woman's reproductive intentions and desired family size.

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To receive a copy of any of the reference materials,
contact the Extending Service Delivery Project at htsp@esdproj.org.