



Evidence to Action for Strengthened Family Planning
and Reproductive Health Services
for Women and Girls Project

Literature Review:

Reaching Young First-Time Parents for the Healthy Spacing of Second and Subsequent Pregnancies

July 2014



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E2A EVIDENCE TO ACTION
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E2A Overview

The Evidence to Action Project (E2A) is USAID's global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive healthcare needs of girls, women, and underserved communities around the world by increasing support, building evidence, and leading the scale-up of best practices that improve family planning services. A five-year Cooperative Agreement awarded in September 2011, E2A is led by Pathfinder International in partnership with the African Population and Health Research Center, ExpandNet, Intrahealth International, Management Sciences for Health, and PATH.

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Acronyms

CHARM	Counseling Husbands to Achieve Reproductive health and Marital equity
CSPD	Civil Status and Passports Department
DHS	Demographic and Health Survey
ICRW	International Center for Research on Women
IUD	Intrauterine Device
JHCP	Jordan Health Communication Partnership
LARC	Long-acting reversible contraceptive
PRACHAR	Promoting Change in Reproductive Behavior
PRB	Population Reference Bureau
PSI	Population Services International
SAA	Social Analysis and Action groups
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VSLA	Village Savings and Loan Approach
WHO	World Health Organization

Executive Summary

Significant evidence shows that both mothers and babies are healthier if at least 24 months elapse between pregnancies. Yet inequitable gender norms, cultural norms around fertility, and other related factors, such as provider bias, lead young married mothers to have closely spaced pregnancies, compromising their health and that of their newborns, and diminishing their life chances. Programs often neglect young married women in favor of older women, or focus solely on delaying marriage and first pregnancy in an effort to improve girls' and women's' health and life chances; very little programming has been dedicated to spacing second and subsequent pregnancies by at least 24 months among young married women, despite the enormous need. For the purposes of this paper, this neglected group of young married/in-union women under the age of 25 and their partners, who are pregnant or already have one child, are referred to as *first-time parents*.

This paper provides a review of evidence (published and grey literature) in an effort to describe successful programs and programmatic elements that influence first-time parents' use of contraceptives for the purpose of spacing their second and subsequent pregnancies in developing countries. The authors conducted searches on Medline and other key databases and websites, emphasizing research published in the past five to ten years in the following areas: adolescent childbearing, teenage pregnancy, birth spacing, first-time parents, delaying second birth, adolescent contraceptive use, adolescent contraceptive decision making, and household gender dynamics.

The literature review revealed that relatively few programs exist to delay second and subsequent births or limit future births among young married women, and even fewer are adequately evaluated. A description of those programs that had some evidence of effectiveness and the strategies that they used to reach first-time parents is provided. Elements of these of programs include:

- addressing social norms, gender roles, and spousal communication of first-time parents;
- working with mothers-in-laws to support first-time parents to space their second and subsequent pregnancies;
- strengthening provider understanding of and capacity for the need for intervention with the adolescent postpartum client;
- emphasizing postpartum family planning with first-time parents (both mothers and fathers) and offering long-acting methods in appropriate contexts;
- training providers to encourage fathers' participation in prenatal, delivery, and postnatal care without jeopardizing young mothers' agency; and
- building social support for the reproductive needs of first-time parents through community mobilization.

A wide variety of demand-side factors at individual, familial, community, and state levels as well as factors on the supply side, including provider-client interaction, service delivery policies, and regulation, determine a first-time parent's use of contraception. Given this, programs that successfully combine a number of approaches to offer an integrated package of information and appropriate services for a woman, her partner, and her support network will likely be the most effective in increasing reproductive decision making, use of contraceptives, and better spacing of additional pregnancies. Effective interventions to address first-time parents should employ a variety of context-specific components.

The review also highlights the need for further programming and research to discern the most effective ways to increase contraceptive use among first-time parents and to increase young women's decision-making power. Areas for future research include:

- effective approaches for adolescent fathers;
- the impact of program interventions on birth spacing, challenging gender norms, and strengthening spousal communication among young couples regarding contraceptive use and birth spacing; and
- effective interventions to reduce violence among first-time mothers.

I. Introduction

Most reproductive health programs for young women aged 10-24^a have focused solely on delaying marriage and the first pregnancy in an effort to improve girls' and women's health and life chances, inadvertently neglecting the needs of young women who already have a child to space their second and subsequent pregnancies. A majority of these mothers marry as adolescents,¹ often to men substantially older than they are, and live in societies that value large families. Society places married adolescents at a disadvantage: they are under social pressure to assume their adult status and to prove their social value by demonstrating their fertility and having many children.² Their age, lack of education, limited agency and power in their marital relationships and their economic dependence, trap them in a cycle of poverty and rapid, repeat childbearing.³

Globally, one in five women has a child by age 18, and in the poorest regions it is one in three, accounting for 11 percent of all births.⁴⁻⁵ Demographic and Health Survey (DHS) data from 11 countries in East Asia and the Pacific indicates that a significant proportion of married and unmarried adolescent girls between the ages of 15 and 19 space their births less than 18 months apart.⁶ Many pregnancies among young women are unplanned or poorly timed, contributing to a high rate of unsafe abortions. In 2008, an estimated 8.7 million unsafe abortions, representing 41 percent of all unsafe abortions in developing regions, took place among women aged 15 to 24.⁷

There is a strong correlation between close birth-to-pregnancy intervals (less than 24 months) and poor maternal, infant, and child health outcomes,⁸ including higher rates of pregnancy-related complications for women less than 20 years.⁹ Maternal morbidities among all women for birth-to-pregnancy intervals of less than 24 months include maternal nutritional depletion, folate depletion, cervical insufficiency, and incomplete healing of the uterine scar from the previous cesarean delivery, among others.¹⁰ The risk of prematurity and low birth weight doubles when conception occurs within six months of a previous birth, and children born within two years of an elder sibling are 60 percent more likely to die in infancy than are those born more than two years after their sibling.¹¹

Additionally, closely spaced pregnancies contribute to the rapid population growth in many countries where there are not enough resources to support this growth. The fertility rate among the poorest adolescent girls has been increasing in many countries over the past 15 years, with adolescent girls from the poorest fifth of the population four times more likely to be pregnant than those from the richest fifth.¹² Sub-Saharan Africa has the highest birth rate among under-18-year-olds (especially Malawi, Mozambique, Mali, Chad, and Niger), followed by South-Central and Southeastern Asia.¹³ Once married, and particularly once with children, young women and girls have very limited chances to continue their schooling and obtain employment opportunities outside of the home, leading them to a future where they are completely dependent upon their male partners and other family members for financial resources. A lack of education and financial independence inhibits young women's and girls' reproductive agency and contributes to their social isolation, as well as diminishes their chances and choices concerning access to health services, including family planning services.¹⁴⁻¹⁶

^aAs much as possible, the paper has drawn on data and literature that reflect the full 10-24 year old age cohort; however, in some cases, the authors have included data on a subset of the age group due to data limitations.

Increasing young women’s access to contraception is widely recognized as a cost-effective investment to achieve health and development goals.^{11,13, 16-18} Significant evidence shows that both mothers and babies are healthier if at least 24 months elapse between one birth and the next pregnancy, yet inequitable gender norms and cultural norms around fertility and other related factors such as provider bias lead young married mothers to have closely spaced pregnancies, compromising their health and that of their newborns, and diminishing their life chances. These mutually reinforcing factors operate at the individual, household, community, and structural levels, curtailing young mothers’ reproductive agency—that is, their ability to decide and act on their fertility intentions.¹⁹

Rates of contraceptive use among married youth ages 15 to 24 years are much lower than for married women ages 30 to 34.²²⁻²³ Less than one-third of currently married girls in low- and middle-income countries who want to avoid pregnancy are using a modern method of contraception. In sub-Saharan Africa, 67 percent of married adolescents who would like to avoid or delay pregnancy for at least two years are not using any contraceptive method.²⁴ In South Central and Southeast Asia, the proportion is 54 percent and in Latin America and the Caribbean, it is 36 percent.²⁴ Current use of modern contraceptive methods among adolescents 15-19 varies substantially by region, from 11 percent in Asia (excluding China) to 13 percent in Africa and 55 percent in Latin America and the Caribbean.²⁵

Young married women & girls and the Demographic Dividend

Young married women and girls in developing countries represent a significant portion of the population under the age of 25, who now comprise 44 percent of the world’s people.²⁰ This enormous yet underserved demographic presents the world with an unprecedented opportunity to accelerate economic development and reduce poverty, or what is termed the demographic dividend. To reap the benefits of this demographic shift, however, both fertility rates and child deaths must drop. Ensuring voluntary contraceptive choice among young married women and girls, expanding their reproductive decision-making power to decrease rates of unintended pregnancies, and addressing the abundant unmet need for family planning will contribute to that, while reducing maternal morbidity, infant and child mortality, and unsafe abortions.^{3, 21}

There is increasing evidence around effective strategies to delay marriage and the first pregnancy as synthesized in the World Health Organization’s guidelines on preventing early pregnancy among adolescents.¹² However, less is known about programs that intentionally take into consideration the fertility intentions of first-time parents and address their unmet need for contraception.^{12, 26}

2. Purpose of Report

This paper provides a review of evidence that can be used to generate research and develop programs encouraging young married (or “in union”) mothers under the age of 25 and their partners who have one child—referred to throughout this paper as *first-time parents*—to fulfill their fertility intentions, and at the same time, space their pregnancies in a way that ensures the best possible health outcomes for the mother, baby, and entire family. The paper examines the many contributing factors that lead to the high incidence of rapid, closely spaced pregnancies among this group, as well as interventions from which learning can be drawn to design programs to reach first-time parents and encourage healthy spacing practices. It also provides specific recommendations on how that programmatic learning can be applied and the gaps in the evidence can be filled. Given the large youth population in the developing world, and the persistence of early marriage/early childbearing, addressing the reproductive health and unmet family planning needs of first-time mothers and fathers could significantly improve maternal and child health, and contribute to efforts to reduce total fertility. In many settings, this would establish the conditions

necessary to bring about a demographic dividend, ultimately contributing to economic improvements and improvements in development.

This paper examines published and grey literature in an effort to describe both enabling and constraining demand- and supply-side factors that influence first-time parents' use of contraceptives for the purpose of spacing their second and subsequent pregnancies. The report focuses on factors that influence young married women at individual, familial, community, and state levels (demand-side determinants), as well as those determinants on the supply side, including provider-client interaction, service delivery policies, and regulation that hinder or support women's ability to make decisions about their fertility and receive services. This knowledge is important since the majority of interventions targeting young women do not reach those who are married, and most services for married women do not adequately reach those of low parity who are most often under the age of 25.²⁷ As a publication of the USAID-funded Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls (E2A) project, this paper can be used to help fill the gap in evidence and programs related to interventions promoting spacing of second and subsequent pregnancies and increased contraceptive use among first-time parents.

3. Methodology

This review is designed to illustrate the range of best practices relevant to reducing unmet need for contraception among first-time parents. The literature search was guided by key themes suggested by key informants, experts in sexual and reproductive health and youth development, with whom 32 interviews were conducted (see Appendix I for names and organizations). The purpose of the interviews was to scope as completely as possible the body of literature from which to draw, and to identify the key themes and assumptions guiding this work. The authors conducted searches on Medline and other key online databases and websites, emphasizing research published in the past five to ten years in the following areas:

- Adolescent childbearing, teenage pregnancy
- Birth spacing
- First-time parents
- Delaying second birth
- Adolescent contraceptive use, adolescent contraceptive decision making
- Household gender dynamics

Additional topics reviewed included published and unpublished literature on contraceptive uptake among young mothers and their male partners; family planning and maternal health programs and evidence of relevance to first-time parents; gender and its connections with health; youth-friendly interventions; and HIV, adolescent sexuality and gender norms. This review of the literature resulted in over 26 documented interventions for first time parents and/or adolescent mothers. Those programs that exclusively work with *unmarried* first time parents (e.g., single mothers) were excluded from the highlighted case studies in this literature review, based on the definition of FTP used in this paper: young married/in-union women under the age of 25 and their partners, who are pregnant or already have one child (however, some relevant lessons learned from these programs are included). Therefore, of these 26 programs, 13 were selected for in-depth analysis, six were included and described in the highlighted case studies of this literature review, and two others were considered “programs to watch”, as results from these two interventions are not yet available.

4. Causes of Closely Spaced Pregnancies among Young Married Women and their Partners

Cultural norms that reward high fertility may limit demand for contraception among young mothers in resource-poor settings. Further, young women have limited decision-making power within households and are affected by their age (young people are often considered too immature by older spouses or family members, and are not allowed to make these types of decisions independently); gender norms; and inequalities that inhibit, rather than encourage, their contraceptive choice. To understand the underlying factors that prevent or facilitate first-time parents' use of contraception and spacing of their pregnancies by at least two years, it is necessary to examine these determinants, keeping in mind that adolescents' age, cognitive development, and other factors pose challenges to their ability to make healthy decisions about their sexual and reproductive lives and access essential—and sometimes lifesaving—services.²⁸

4.1 Demand-Side Factors

The demand young married first-time mothers have for contraceptive services is determined by a range of factors, including their own knowledge and desires, the desires of their partners and families, peer and community norms, power dynamics in their marriage and homes, and the broader environment in which they live.²⁹

Many young married women lack the requisite knowledge around the benefits of healthy timing and spacing of pregnancies and contraception that is needed to use contraception and seek services. Even when they have the knowledge, young women may not have the agency (self-esteem, self-efficacy, self-confidence) and negotiation skills to successfully communicate their intentions and desires to a partner, health provider, or their family, nor the ability to act upon those intentions or desires. Further, adolescent mothers are still developing cognitively and may lack the capacity to make decisions weighing future risks and benefits. Evidence suggests that many young women, especially young married adolescent women, do not know where to seek health services and face challenges in securing permission to obtain health services and accessing funds for transport and services.³⁰⁻³² Even if funds are available, young mothers in some parts of the world may face other restrictions to their mobility that prevent them from seeking services, such as not being able to leave the home unaccompanied.^{2, 33}

Beyond the individual knowledge, cognitive, and access barriers first-time mothers face in obtaining health services, young married women in developing countries often have a fatalistic perspective on the timing and conditions of marriage, sexual intercourse, and their fertility.^{34, b} This begins early for girls and young women, but becomes particularly evident at marriage. Some young women and girls are in

^b Programs should also recognize the importance of fertility desires of youth who want to get pregnant and youth who are ambivalent about a future pregnancy. For example, Speizer and White (2008) advise about how rarely studies recognize youth's desire to become pregnant as a strategy to increase their social status (as a parent), or fulfill emotional and/or economic needs. In their study they found that "among the sexually active youth, about one third want to get pregnant soon, half want to delay, 7% want no more, and 11% are unsure about future childbearing" (p.536). This finding confirms the need of programs having different approaches to address youth-specific life stages, context, social and cultural norms, and gender-imbalanced relationships.

arranged marriages to men significantly older than they are. Girls who marry early typically have lower levels of educational attainment, limited or nonexistent social networks, restricted mobility and little access to mass media. Once married, the combination of their social status, young age, and prevailing inequitable gender norms exacerbates unequal power dynamics within their marriage and family that disenfranchise them and curtail their reproductive agency and decision-making capacities.³⁵⁻³⁶ For example, a study of married girls in Bangladesh found that most of the girls had borne children before they were emotionally and physically ready as a consequence of fertility decisions that were largely not their own.³⁷ Literature shows that young women's bargaining power within their marital homes is influenced by family structure (e.g., polygamy), who controls income and assets, their age at marriage, and their educational level.³⁸

Although family planning in many countries is considered a woman's domain, men, and in some instances, extended family such as mothers-in-law, may play the role of gatekeepers, determining the number and spacing of children, and controlling young married women's access to family planning information, counseling and services.³⁹⁻⁴⁰ Desires and opinions of the male partner, real or perceived, factor heavily in a young woman's ability to use contraception and choose when and if to have a child. It is not uncommon for young women to perceive that their male partners are opposed to family planning, (even when the male partners are actually supportive), making them afraid to use a method or to use it clandestinely.² Young married mothers are also bound by social and cultural norms, which in some places dictate that women seek spousal consent for health care and access to financial resources.

Though men may be gatekeepers who prevent women from seeking information and services related to contraception, research looking at this issue for all women of reproductive age suggests that when men are educated about reproductive health issues, especially the benefits of contraception for the health of mothers and children, they are more likely to support their partners in decisions about contraceptive use and family planning.⁴¹⁻⁴² Male partners' knowledge of and positive attitudes toward contraception along with improved spousal communication are important factors in young women's—and couples'—uptake of contraceptives.⁴³⁻⁴⁵ Preliminary results from work in India show that engaging men as caregivers increases contraceptive use among fathers who have a child less than one year of age.⁴⁶

In addition to gender and power dynamics within the marriage that influence young married mothers' demand for contraception, these young women are under tremendous family and social pressure—from spouses, mothers-in-law, peers, and competition with co-wives (in polygamous settings)—to prove their fertility. Many give birth before reaching their first wedding anniversary, especially in settings where sons are preferred.⁶ In settings where son preference is strong, the literature indicates that women and girls are more likely to have multiple pregnancies within a short interval (less than 24 months) if their first child is a girl,⁴⁸ and the desire for sons is a significant motivation for women to have the next child.⁴⁹ A 2008 analysis of Demographic and Health Survey (DHS) data from 65 countries found that the relationship between son preference and continued childbearing is strongest in Central and South Asia, and weaker, but still significant, in the Middle East, North Africa, and East Asia.⁵⁰

Laws, policies and regulations (formal and informal) can also facilitate or impede (purposefully or inadvertently) young women's demand for and uptake of family planning and reproductive health services. Governments' direct or indirect support for contraception and government policies (pro- or anti-natalist) are important influences⁵¹ since they have a direct bearing on resources to meet the family planning needs of first-time parents. How these policies and regulations are understood and operationalized at the various levels—household, community, facility, and state level—needs to be understood.⁵²

4.2 Supply-Side Factors

In addition to negotiating the demand-side determinants for seeking delay of second pregnancies, young married women face a host of supply-side determinants that may affect their ability to obtain services. These include provider bias, distance to a health facility, and community- and facility-based health services that do not offer the full range of contraceptives.⁵³ Furthermore, costs for health services, which include actual payments at health services as well as costs for transport and opportunity costs of time away from income-generating activities or household responsibilities, may impede access.⁵⁴ Young mothers are less likely than adult women to have funds to pay for services and/or transport, and the cost of more expensive contraceptive options, such as implants or intrauterine devices (IUDs), may be prohibitive for them.³² Integrating family planning into child health and maternal health services (e.g., during postnatal care) can help mitigate some of these opportunity and financial costs by addressing multiple needs in one service visit.⁵⁵

Many married young women who do access family planning and reproductive health services may find them oriented towards older married women (e.g., focused on high-parity women with an emphasis on limiting rather than on encouraging younger women to space).⁵⁶ The treatment young married women receive at the hands of health care providers—including provider attitudes, their ability to initiate conversations on family planning and pregnancy spacing, effectively counsel young married clients based on their levels of socio-cognitive development, fertility desires, provide the method of choice, and provide accurate information on method use and side effects—influences the uptake and continued use of contraceptive methods.

The power dynamics inherent to the relationship between clients and providers also affects the uptake of services. There are communities, for example, where the shortage of female service providers interferes with access to and use of family planning and reproductive health counseling and services.⁵⁷⁻⁵⁸ Some providers, as well, still have concerns about the side effects of hormonal contraceptive methods (oral pill, injectable, and implant), especially infertility, and may be reluctant to counsel young women to use family planning because they do not want to be blamed in the event a young woman does experience a fertility problem.⁵⁹ Others are reluctant to offer long-acting methods to young women due to misinformation or lack of knowledge about existing evidence.⁶⁰ Prohibitive rules and regulations, such as restricted clinic hours, eligibility criteria for care and counseling, need for spousal consent, provision of an inadequate supply of contraceptives (given young married women's limited mobility) are also constraining factors.^{61,32}

In addition, even when young women do seek family planning services, they may experience other demand-side constraints later on (e.g., lack of support by a partner or influential family member or insufficient knowledge of common side effects) that reduce their ability to effectively use their chosen method or result in discontinuation.

5. Interventions Relevant to the Needs of First-Time Parents

A review of over 26 adolescent and youth sexual and reproductive health programs in developing countries revealed that there are a limited number of programs that intentionally address the contraceptive needs of first-time parents to space second and subsequent pregnancies by at least 24 months or to limit future births. This paper includes those programs that intentionally addressed the needs of first-time parents and had documented results. Based on evidence collected from the review, this paper highlights key interventions or program elements that seem promising for addressing demand for family planning and improving the reproductive health and wellbeing of first-time parents. This next section reviews what we know about programs that address the links between demand- and supply-related determinants of contraceptive use relevant to first-time parents. This section also provides a

description of these programs and their strategies, which address demand- or supply-related determinants, and where applicable, assesses whether they attempt to address inequitable gender norms, roles and relations. These interventions have sought to improve reproductive health outcomes, such as contraceptive uptake and healthy timing and spacing of pregnancies, improved gender outcomes, increased couple communication, and joint decision making.

PRACHAR Project, India

Promoting Change in Reproductive Behavior (PRACHAR) aimed to delay age of marriage until at least age 18 for women and 21 for men, delay first birth until the mother is aged 21, and—most relevant to our analysis—encourage young couples to space their pregnancies by at least three years through an audience-segmented behavior change approach that took into consideration age, gender, parity, and marital status. Interventions such as PRACHAR are crucial since almost half of women in India are married by age 18 and therefore have children very early, diminishing their opportunities for personal development, which can negatively impact their health, family, social life, and economic output.⁶²

Strategy (demand with some elements of supply)

PRACHAR engaged entire communities to shift norms around healthy timing and spacing of pregnancies among young people. The program reached more than 1 million people over 11 years by conducting targeted outreach with specific messages based on age, marital status, parity, and gender. Tailored interventions were used to reach different groups, including unmarried adolescent boys and girls, newlyweds, married young women who were either pregnant or immediate postpartum, young couples with children, and gatekeepers such as in-laws and parents. Most relevant to this paper were the interventions that focused on young married pregnant or postpartum women and single-parity couples. Young pregnant women and young women with one child received home visits by female community health workers who provided sexual and reproductive health education and counseling as well as referrals to health facilities for sexual and reproductive health services. In addition, both first-time mothers and fathers participated in same-sex group meetings led by female and male change agents respectively that emphasized mutual respect for spouses' opinions and decisions; joint informed decision making about reproductive health and contraceptive use; and male involvement including male condom use. Related issues such as son preference were also addressed. Gatekeepers, such as parents and in-laws, were engaged to provide a supportive environment for the uptake of contraceptive services and avoidance of early and closely spaced births.⁶³⁻⁶⁴

Results

PRACHAR demonstrated that culturally appropriate, community-based behavior change programming targeting young people and those who influence their decisions can affect change in sexual and reproductive health knowledge, attitudes, and contraceptive use to delay and space pregnancies. PRACHAR Phase I was evaluated through surveys at baseline (2002-03) and endline (2004-05) in the intervention and comparison areas. A cluster sampling methodology was used to interview 1,995 women in the baseline survey and 2,080 women at endline. The evaluation found that women with one child in the intervention group experienced a significant increase in contraceptive use to space the second pregnancy, from 6 to 25 percent, while for women in the control group, the figures were 4 and 7 percent respectively.⁶⁵ Results indicate that the wife's participation in decision making about contraceptive use increased significantly in the PRACHAR intervention areas from baseline to endline. Adjusted regression analysis showed that couples with one child were 1.2 times more likely to use contraception when wives participated in the decision making. Results also showed that couples in which both the respondent and their partner were exposed to PRACHAR had the highest odds of contraceptive use (3.7 among female respondents, 2.6 among male respondents), whereas couples in which only the respondent was exposed to PRACHAR had lower odds of contraceptive use (2.0 among both female and male respondents).⁶³

First-Time Parents Project, India

The Population Council, in partnership with the Child in Need Institute in Kolkata, the Deepak Charitable Trust in Vadodara, and the International Institute for Population Sciences in Mumbai, implemented this project in two rural settings in India. The project targeted newly married young women, young women pregnant for the first time, postpartum first-time mothers, husbands of these young women, mothers and mothers-in-law, health care providers, and the larger community. The majority of participants were adolescents (19 years old or less).⁶⁶

Strategy (demand and supply)

The intervention included three reinforcing components: reproductive health information provision, service delivery quality improvement, and small groups for young married women, including first-time mothers, as a means of enhancing young women's social support networks.⁶⁶ Young married women (zero parity, pregnant, and single parity) received reproductive health information directly through home visits by female outreach workers, clinic-based counseling sessions, discussions in young women's groups, and community health fairs. The information covered sexual and reproductive health topics, sex as a voluntary experience, the need for a delivery plan, and the supportive role young husbands could play, among other things. The program identified male involvement as a key strategy, and made a special effort to reach young husbands through home visits by male outreach workers and neighborhood discussions. When possible, mothers-in-law and senior women in the households of married young women were also reached. The program strengthened the capacity of service providers to meet the special needs of married young women through orientation workshops and provided some clinical supplies, including safe delivery kits to trained traditional birth attendants. Outreach health workers visited mother and baby within six weeks postpartum and continued with bi-monthly follow-up visits for a year. Within the social support groups, young women gained life skills that increased their capacity to act in their own self-interest. For example, they gained legal and financial literacy and learned about gender dynamics within and outside the family, as well as spousal relationship issues, among other topics. The activities were implemented in 24 villages between 2003 and 2004 using a quasi-experimental research design with cross-sectional surveys at baseline and endline.

Results

In order to measure the effects of exposure to the intervention, the project developed indicators designed to measure young women's agency, social support networks, and changes in young women's reproductive health practices. Findings indicate that in both rural settings, the intervention had a significant positive net effect on most indicators, suggesting the interventions successfully increased married young women's autonomy, strengthened social support networks, facilitated improved communication with partners, and improved knowledge of reproductive health. Exposure to the intervention had a significant positive net effect on attitudes towards gender in one site, but did not influence attitudes regarding whether domestic violence was justified in some instances in either site.

Exposure to the intervention also had a significant positive net effect on use of contraceptives to delay first birth. While the evaluation found no significant difference in antenatal care visits among young first-time mothers as a result of the intervention, young first-time mothers who were exposed to the intervention were significantly more likely to have received a routine check-up within six weeks postpartum. In one of the program sites, young mothers exposed to the intervention were significantly more likely to have breastfed their newborns immediately after delivery than young mothers in the control group.⁶⁶ Postpartum visits can provide an opportunity to discuss postpartum contraception.⁶⁷ The study authors concluded: "... 'supply-side' stand-alone health service delivery interventions may not be adequate to meet the special needs of married young women; to be effective, they must be coupled with interventions that address young women's social isolation and relative lack of power."⁶⁶

Community-Based Behavior Change on Postpartum Contraception, India

The Population Council oversaw a community-based behavior change communication intervention in a rural area of Uttar Pradesh that trained community health workers about how to counsel young, pregnant married women with one child or no children in lactational amenorrhea method (LAM) and postpartum contraception.⁶⁷ The intervention reached 959 young women aged 15-24 years.

Strategy (supply focus, with some work on demand)

Medical officers were trained to provide special training to community health workers. The community health workers included 27 auxiliary nurse-midwives, 108 accredited social health activists, and 117 *anganwadi* (local health workers). The community workers used low literacy educational materials such as leaflets, posters, and booklets to educate pregnant women and their mothers-in-laws (or the eldest female family member) on healthy timing and spacing of pregnancy and postpartum contraception. The program also included an education campaign aimed at men in the intervention communities, with messages about postnatal care, infant health, and postpartum contraception.⁶⁷

Results

Use of modern contraceptives at nine months postpartum for spacing was 57 percent in the intervention group versus 30 percent in the comparison group.⁶⁷ A significant proportion of those in the intervention group discussed spacing births with their husbands (63 percent as compared to 39 percent in the comparison group) and 64 percent and 79 percent of women at their fourth and ninth postpartum visit respectively had shared their educational materials with their spouse. It is unclear if the project intentionally sought to transform gender norms or if it upheld existing norms that allowed for decision makers (e.g., partners or mother-in-laws) to decide for (or permit) young women to use postpartum contraception.

Nchanda ni Nchanda (Youth to Youth) Project, Malawi

Save the Children–US initiated the Nchanda project in 1999. Its goal was to improve the sexual and reproductive health of young people by establishing peer education on sexuality and reproductive health within existing youth clubs. The project established 39 youth resource centers, and worked with health providers to increase their understanding of adolescent reproductive and sexual health needs and improve their ability to provide youth-friendly health services. In 2006, with funding from USAID, Save the Children integrated family planning into the project, which included training young community-based distribution agents to counsel and provide family planning commodities to adolescents, and to reach out to adolescent mothers and their partners.

Reaching out to teen mothers strategy (demand and supply)

The project supported ‘resource centers,’ also called teen mothers clubs, where adolescent mothers met once or twice weekly to discuss their common concerns in a safe space. Group members facilitated their own meetings. Typical discussion topics included self-reliance, independence, and economic opportunity, self-esteem, return to school, negotiating family planning and condom use with partners, benefits and side effects of family planning use, safe motherhood, and healthy timing and spacing of pregnancies. Each club was affiliated with one or more adolescent community-based distribution agents, who provided them with family planning information and commodities, such as oral contraceptive pills and condoms. The project trained 17 health providers in the provision of adolescent-friendly services, and worked with 19 staff from public- and private-sector clinics on how to promote services for young mothers through existing peer educators. The male motivator strategy (described below) reinforced the teen mothers strategy by working with men in the community, including the husbands of the young mothers, to increase their support for family planning and young mother’s return to school.

Results

The project reached approximately 2,035 young mothers through the teen mothers clubs. A project evaluation in 2008 found that participants reported a 10 percentage point increase in modern

contraceptive use from 13 to 23 percent. During this same five-year period, adolescents reported that health providers were more qualified, communicated better with youth, and demonstrated greater confidentiality and respect.⁶⁹

Reaching out to husbands: the male motivator strategy (demand)

This intervention targeted the husbands or partners of young women under the age of 25 years with messages focusing on the financial and health-related benefits of family planning. The project trained 40 male motivators (married men over age 30 who use modern contraception) about contraceptive methods, gender norms, and communication skills, and the use of motivational tools to talk with men about family planning. Male motivators recruited young men from 257 villages; 197 men were randomized into the intervention arm and 200 men were randomized into the control arm. To participate in the study, men had to be at least 18 years old and married to/living with a female partner (age <25) with or without children, but who was not currently pregnant or breastfeeding a child younger than 6 months. Over a period of six months, each male motivator conducted five visits with the young men in the intervention arm, giving them information on modern family planning methods, location of family planning services, and the correct use of condoms. Male motivators also helped the men to challenge harmful gender norms, and to improve communication with their partners about family planning and joint decision making.

Results

Baseline and endline surveys were conducted with the male participants in both intervention and control arms. Changes within intervention and control arms and over time related to family planning knowledge, attitudes, and communication practices were assessed and significantly correlated predictors of contraceptive uptake were included as covariates, along with demographic variables, in a multiple logistic regression model.⁴⁴ Men in the program had an average of 1.66 and 1.60 children (in intervention and control arms, respectively). At baseline, none of the respondents reported contraceptive use (by the man or his partner); after the intervention, 78 percent of respondents in the intervention arm and 59 percent of respondents in the control arm reported using a contraceptive method with his wife/partner. Analysis found that men in the intervention arm had significantly higher mean scores on a four item general communication scale (about discussing family planning with partners/others) and on a three item scale measuring frequency of communication (i.e., frequency with which men discussed family planning with partners, family, and other men in the community) compared with the control arm ($p < .05$). Multiple logistic regression analysis found that although none of the demographic variables was a significant predictor of family planning use, ease of discussing family planning with one's wife (OR=1.57, $p < .1$) and frequency of discussing family planning with one's wife (OR 1.62; $p < .05$; related to two of the seven items included in the two communication scales) were found to be borderline significant or significant (respectively) predictors of family planning uptake.⁴⁴

To better understand the role of communication in the intervention's success, a follow-up qualitative study was conducted one year later with the female partners of male participants. This study examined men's responses from the earlier study with those of their partners/spouses. Results indicated that both men and women felt that "spousal communication was an important catalyst for family planning use and/or continuation." (Hartmann et al., 2012: 807). The intervention contributed to positive changes in communication norms and gender roles between the couples, as women were more involved and increasingly thought of as partners. Young women perceived increased respect from their partners and improvements in their relationships as a result of improved communication (e.g., young woman suggested that they were more comfortable talking about a range of issues, not just family planning, after the intervention).⁷⁰

ProFam Urban Outreach Project, Mali

In 2009, Population Services International (PSI) designed a program to reach urban women of

reproductive age with counseling and high-quality, subsidized, long-acting, reversible contraceptives (LARCs). The model integrated the provision of family planning counseling and services, including LARCs, with routine immunization services as a way to reach the largest possible number of women with unmet need.

Strategy (supply with some elements of demand)

After piloting the integrated service delivery model in the private sector, PSI partnered with the Ministry of Health in Mali to implement the model in public sector clinics. Clinic selection criteria included: sufficient infrastructure to ensure confidentiality; demonstrated compliance with infection prevention protocols; existence of competent staff who were able to provide LARCs; and a high client load. Through an 11-day competency-based training, the project trained public sector obstetric nurses and nurse midwives to insert IUDs and implants, manage complications, and provide removal services. The project then advertised the combined services to community members. On child immunization days at the clinics, a dedicated family planning provider from PSI and the trained public sector providers facilitated a group information session on family planning and LARCs to women waiting to immunize their child. Following the group session, interested women could receive individual counseling, a physical exam, and provision of a contraceptive method, including a LARC.

Results

Although the project did not specifically target young women with LARCs, between 2010 and 2011, nearly half of implant acceptors—48 percent—were young women under the age of 25 with at least one living child. The 2012 case study noted that the “the increased use among women under 25 comes mainly from word of mouth.”⁷¹ With respect to first-time parents, this intervention demonstrates that integration of family planning with immunization services can be a good entry point for reaching young mothers with needed information and services. In addition, when young women have increased awareness about LARCs and health staff have the skills to provide LARCs to young women without bias, the demand for LARCs among young first-time mothers can be significant.

Mabrouk! Initiative, Jordan

The *Mabrouk* Initiative for young married couples was launched in Egypt and Jordan in 2004 and 2008, respectively, by Johns Hopkins University’s Center for Communication Program’s Communication for the Healthy Living Project and the Jordan Health Communication Partnership (JHCP).⁷² *Mabrouk* is the Arabic word for “congratulations,” and the project was launched at a group wedding for 150 couples. The idea was to improve health by building the competence of young couples and laying the foundation for lifelong healthy practices.

Strategy (demand)

In Jordan, *Mabrouk I* targeted newlyweds and *Mabrouk II* targeted first-time parents. The *Mabrouk* information package on health issues faced by young couples in the early years of marriage was distributed to the newlyweds and new parents through an innovative partnership with the Civil Status and Passports Department (CSPD). JHCP designed booklets for newlyweds, who received them when they obtained their marriage license. Booklets were also designed for first-time parents, who received them when they registered the birth of their child. Key topics covered in both booklets included the advantages of using modern contraceptives to space pregnancies, benefits of spacing the second birth by three years after the birth of the first child, and basic guidelines for childcare from birth through age three. The project distributed 75,000 *Mabrouk* booklets to each target group.

Results

The project conducted an evaluation of the *Mabrouk* Initiative in 2011 by conducting telephone interviews with a random sample of male and female individuals (newlyweds or first-time parents) who had registered their telephone numbers with the CSPD offices when they picked up their *Mabrouk*

packages. A total of 1,016 individuals (513 men and 503 women) from Mabrouk I and 1,019 individuals (513 men and 506 women) from Mabrouk II were contacted. The evaluation examined whether those contacted were aware of and had read the Mabrouk packages and if they had used family planning and child health services. Although no baseline study was conducted, the evaluation showed that 47 percent of first-time parents reported current use of modern contraceptives. This finding is important because in a traditional society that encourages newlyweds to start having their family immediately after marriage and to produce successive, closely spaced offspring, the project was able to introduce and support positive social and gender norms regarding contraceptive use and longer birth intervals.⁷³

Lessons learned from US-based projects

A review of research on successful evidence-based interventions⁷⁴⁻⁸³ in the United States designed to delay second and subsequent pregnancies among young mothers identified the following approaches as effective, many which could be applied in low-resource, developing-country settings:

- Providing ongoing guidance and support to young mothers within their homes and at the health facility
- Assigning a trained health worker who visits a young mother frequently within her home over an extended period of time to counsel, guide, and mentor her on issues related to family planning, newborn-child care, and interpersonal negotiation skills.
- Reaching the young mother's spouse/partner and in-laws to expand their knowledge in the area of maternal-child health and strengthen their support
- Linking the young mother and her partner with the health facility
- Strengthening the young mother's social support system by linking her with other young mothers through mothers' clubs and life-skills training programs
- Working directly with or linking the spouse/partner with a male peer educator to help him adopt healthier male gender norms, and improve couples communication and joint decision-making skills related to family planning and other sexual and reproductive health matters
- Mobilizing community members and key stakeholders to reintegrate young mothers into school to help them complete their education

6. Programs to Watch

The programs discussed here show potential effectiveness in providing information and reinforcing negotiation skills, social, family, and community support, as well as economic and educational empowerment to strengthen young married women's agency over their reproductive lives. Although some of these programs do not directly address first-time parents, their strategies may be very useful in building the decision-making power of young mothers and their ability to act on their own fertility preferences.

Gender Equity-Focused, Male-Centered Family Planning for Rural India (CHARM)

The University of California San Diego, the Population Council, the National Institute of Research in Reproductive Health in India, and other institutions are implementing and evaluating a male-centered family planning program aimed at transforming inequitable gender ideologies and norms (e.g., son preference, wife abuse) and poor marital communications associated with low contraceptive uptake by

young rural Indian couples. The project involves the development and testing of the CHARM intervention (**C**ounseling **H**usbands to **A**chieve **R**eproductive health and **M**arital equity). CHARM will be delivered by village health providers through a public-private partnership with primary health centers and private providers. Population Council will conduct a randomized control study in 50 villages to assess treatment effect on spacing, contraceptive use, pregnancy, and unmet need for family planning. Preliminary results are available and final results are expected later in 2014.^c

Gender Roles, Equality and Transformation (GREAT) Project, Uganda

The GREAT Project, led by Georgetown University's Institute for Reproductive Health, in collaboration with Pathfinder International and Save the Children, aims to improve gender equity and reproductive health in Northern Uganda, a post-conflict region. The project facilitates the formation of gender-equitable norms and the adoption of attitudes and behaviors which will positively influence health outcomes among boys and girls ages 10 to 19 years. The five-year project, funded by USAID, includes one year of formative research, two years of pilot testing, and a two-year scale-up phase. Using a life-stage model, different components of the program are tailored for very young adolescents, older adolescents, and married and/or newly parenting adolescents (first-time parents). Adolescents are engaged through small-group reflection and dialogue using a toolkit of participatory activities that are adapted for each cohort, and linked with youth-friendly sexual and reproductive health counseling and services through trained Village Health Teams. The toolkit is designed to be easily scalable.

Communities and gatekeepers are engaged through the implementation of the community action cycle as well as components of the toolkit that were specifically developed for use by community members. The GREAT project also supports a radio serial drama, which is broadcasted throughout the area. The radio drama includes married adolescents and first-time parents as central characters, and the drama links to and reinforces the small group and community interventions. Evaluation of the pilot phase of GREAT is ongoing with results expected in 2014.⁸⁴

7. Filling the Evidence Gap Around First-Time Parents

There are few rigorously evaluated projects that address delaying second and subsequent pregnancies. This literature review and analysis of programmatic interventions has highlighted several gaps in what we know about how to increase contraceptive use, ensure the healthy spacing of second and subsequent pregnancies among young married women and their husbands, and increase young women's agency and decision-making power.

Few interventions exist to delay second and subsequent births among young married women.

Programs tend to focus on young people (i.e., youth-friendly services, especially for unmarried youth), married women, or even on mothers in general, but there are few interventions that focus on the specific information and service delivery needs of young married women with a child. Likewise, programs that address the sexuality education needs of adolescents do not differentiate between those who are married or unmarried, and those who have already had one child, as compared to those who have not yet had children.⁸⁵⁻⁸⁷

^c For further information, refer to: <http://clinicaltrials.gov/ct2/show/NCT01593943>.

When programs for young, married mothers or couples do exist, they are often not well evaluated.

Evaluated programs that address the specific needs of young mothers and first-time parents, such as strategies to generate demand and community support or to improve sexual and reproductive health services for young people are few.⁸⁸ A 2009 Cochrane review of interventions in developed and developing countries concluded that while results show that multiple interventions (combinations of educational and contraceptive interventions) lowered the rate of unintended pregnancies among adolescents, evidence of the effect on outcomes, such as contraceptive use and birth spacing, was not conclusive.⁸⁹

When evaluation does take place, program data are not always disaggregated by age, marital status, and parity. For many programs, the age range of participants included in the intervention is not always clear. As a consequence, the evidence needed to address the needs of vulnerable subgroups of young women is often weak.⁹⁰ As a case in point, a new World Health Organization publication on the causes and consequences of contraceptive discontinuation does not present age-disaggregated data.⁹¹ A review of control and comparison interventions on girls and health in low- and middle-income countries similarly found that only 3 of the 12 interventions matching their selection criteria had a clear marital status criteria (of which 2 were exclusively focused on unmarried girls and 1 was focused on married girls), and only 1 of the 12 interventions “made a distinction in its design, targeting, and content, regarding whether a girl had a child or not.”⁹²

We know little about work with adolescent fathers and its effect on family planning use and birth spacing. While in much of the world, the partners of young mothers are older, there are still significant numbers of young fathers.⁴⁰ Increasing attention is being paid to their role. Collaboration between PROMUNDO, Men Care, and Sonke Gender Justice Network has led to the recent development of Program P, a tool which “identifies best practices on engaging men in maternal and child health, caregiving, and preventing violence against women and children.”⁹³ This global fatherhood campaign promotes the involvement of men, including young men, as equitable, non-violent fathers and caregivers. A key emphasis is on building the capacity of men to support their female partner. Likewise, work in rural Maharashtra State, India on the UNFPA-funded *Samjdhari Jodidar* project (implemented by the Centre for Health and Social Justice, New Delhi) will provide further information on how to effectively involve young fathers, but more attention is needed to this area.

We know little about the effects of interventions that challenge gender and cultural norms on young couples’ use of contraception and birth spacing. While some programs, such as PRACHAR, have demonstrated an effect on joint decision-making and increased contraceptive use among married adolescents, few studies appear to analyze the effects of promoting positive gender norms and attitudes on contraceptive use among married adolescents (including first-time parents) in developing countries.^{70,94-95} There is a need for additional research in this area to better understand the causal pathways between improved gender norms and increased contraceptive use among young couples, including those who have become parents.

We need effective interventions to reduce gender-based violence against young women. Gender-based violence—and the control exercised through the threat of violence—dramatically reduces young women’s ability to make decisions on their own behalf, including deciding to seek health services and use contraception. Sexual coercion and a general lack of decision-making power increase the possibility that young women will experience an unintended pregnancy. Interventions are needed to reduce and mitigate the consequences of intimate partner violence among young married women and girls.^{37, 96} There is also evidence that implicates mother-in-laws in violence against their daughters-in-law,⁹⁷ as well as evidence that suggests that they can play a positive role in family dynamics and decision making related to family planning and reproductive health.^{39, 98} We need to know more about family dynamics

and how to influence them in a positive direction to help first-time parents use contraception and space their second and subsequent pregnancies.

8. Programmatic Recommendations for Reaching First-Time Parents

There is a tremendous need to address the fertility desires and contraceptive needs of first-time parents. This review of programs and research offers insight into the types of interventions that can stimulate demand for contraception among first-time parents and improve the quality and supply of reproductive health services for young mothers. Key demand-side recommendations that emerged from this review include:

1. Build young mothers' human and social capital.

Building young mothers' social capital and developmental assets is necessary for ensuring they have the self-efficacy, agency, and skills for healthy decision making. More educated girls who earn income, who control the income they earn, and who can accumulate financial assets are better able to make decisions about their health⁹⁹ and to act on their decisions.¹⁹ The programs we reviewed recommend a number of ways of doing this:

- Provide mentoring and social support between adult women and adolescent and young mothers. Home visits, like those implemented under PRACHAR, could easily be applied elsewhere. The strength of the relationship between girls and the outreach workers, who functioned as mentors, appears strongly associated with girls' success in avoiding second or subsequent pregnancies.⁸⁰ Home visits allow those in hard-to-reach communities to access sexual and reproductive health information and services. Home visits can be used to reach both men and women and the extended family.
- Bring young mothers together in supportive groups as a way of building their social networks, helping them to overcome their isolation, and sharing information. These groups can facilitate discussions about topics such as sexual and reproductive health, contraceptive use, pregnancy spacing, child care, communicating with spouses, managing the expectations of their mothers-in-law, etc., and can bring young women in contact with their peers, and create the platform for building negotiating skills to help them act on their intentions.
- Support young mothers' opportunities to stay in or return to school after marriage and/or childbearing. Building on evidence from US-based programs, an important intervention in the lives of parenting girls is to increase educational opportunities. Enabling young women who are pregnant or who have children to continue their schooling can empower, inform, and connect them on many levels.¹⁰⁰ This requires reducing stigma and discrimination toward adolescent mothers in schools,¹⁰¹ as well as providing other types of support such as childcare.
- Build young mothers' economic resources via income-generating activities. Having access to financial resources is widely recognized as integral to young women's ability to make decisions on their own behalf and act on them, regardless of their marital status. Women with greater autonomy, education, wages, and labor market participation experience improved reproductive health outcomes.¹⁰² As with schooling, a crucial factor in improving young mothers' ability to work is the availability of childcare.

- Teach young mothers their rights. Teaching girls and young women their rights and giving them the skills to demand or negotiate for them is a matter of both accountability and governance.¹⁰³ Programs should seek to both increase young women’s awareness of their rights and create an enabling environment so that they can exercise these rights and fulfil their own fertility desires.

2. Cultivate the support of husbands, parents and in-laws.

- Engage young husbands consistently, with a focus on building equitable, supportive marriages. A few programs train young husbands to be more informed and supportive of joint decision making around when and if to have children. Indeed, there is increasing evidence that promoting gender- equitable norms among boys and young men can influence sexual and reproductive health outcomes.^{70, 95} There are different opportunities to engage men around reproductive health, on which programs for first-time parents could capitalize. For example, involving men in face-to-face couples’ counseling during pregnancy; this could be an opportunity to discuss healthy spacing of the second and subsequent pregnancy and contraceptive use.
- Work directly with parents, in-laws, and other family gatekeepers to support reproductive decision making among first-time parents. Parents play an important role in influencing the timing of marriage and childbearing among their children and daughters- and sons-in-law.^{104,105} Support and outreach to mothers-in-law about the health and well-being of young mothers is important, as these older women have great influence on the reproductive lives of young wives.

3. Create an enabling environment for the reproductive planning of young, first-time parents.

- Promote community dialogue about sexual and reproductive health and rights, gender norms, expectations around fertility, and the importance of couples’ communication and joint decision making to facilitate and support the decisions made by young first-time parents. Community-based interventions are needed to change social norms in an effort to increase the acceptability of young married couples’ contraceptive use. These kinds of changes in norms have been accomplished in various programs through community conversations, mass media campaigns, and peer education. Programs should tailor messages and activities for them to resonate with various community gatekeepers.
- Address norms around son preference in the context of declining fertility. Promoting gender-equitable attitudes toward sons and daughters is critical so that **all** children are valued. Without such efforts, families will still want young women to produce not just children, but *male* children. Where son preference is strong, and the first child is a girl, young women/couples will likely find it much more difficult to delay the second pregnancy.

Making health services more responsive to young people requires ensuring accessibility, availability, affordability, and coverage, and high-performing health workers who deliver quality services that are tailored to the needs of young married women. Supportive policies, laws, and systems are also essential. Important supply-side recommendations from this review include:

4. Accessibility, availability and coverage: ensure the services exist and can be accessed.

- Link pregnant adolescents and first-time parents to reproductive health services. Many married first-time parents are isolated within their homes and communities and face multiple barriers to accessing facility-based services.¹⁰⁶ This makes targeted community-based outreach and home visits, especially in the postpartum period, important strategies for reaching first-time parents

and linking them with contraceptive services.⁶ Community-based education should reach both members of the couple and their families. Where feasible, outreach efforts should include education for and advocacy with community leaders.¹⁰⁷

- Husbands and other key family members should be encouraged to be involved, while still maintaining young women's autonomy. Health facilities should encourage male involvement in their partners' reproductive health,¹⁰⁸ where feasible and acceptable to young women. When counseling first-time parents on healthy spacing of pregnancies and contraceptive use, the needs and knowledge of both young women and their partners should be addressed.⁹⁶
- Reduce costs to young people.^{12,109,110} Even modest costs can end up excluding young people from health services, as research on universal health coverage has shown in many countries.¹⁰³ Access can be facilitated by reducing these costs in small ways. Removing user fees and providing vouchers and cash transfers can increase young women's use of services.⁹⁹

5. Improve quality of care from the perspective of young mothers.

- Enhance the accountability of providers to the young mothers they serve. Young mothers' lack of decision-making power at home is echoed by the lack of respect they frequently receive in clinical settings. Programs should offer training to providers that enables their understanding of the development of adolescents and appropriate skills to meet their socio-cognitive needs. Respectful engagement, and supportive, high-quality information and services that offer the full range of contraceptive choices are essential to encouraging young women's use of services.⁴⁸
- Include information about young married mothers' limited autonomy in reproductive decision making. Providers must improve their own skills to empower young mothers, promote communication among first-time parents, and ensure that the voice of the young mother is heard. Many would also benefit from gender-sensitization training, since they often unconsciously convey their personal or cultural biases around early pregnancy and/or contraceptive use toward young mothers.¹¹¹⁻¹¹²
- Providers must make the most of a young, first-time mother's visit to a facility, since her return to that facility is unpredictable. For example, when young mothers present at health services for antenatal care and/or delivery, providers may be able to assist them in developing a "discharge plan," which can include life, parenting, and family formation plans, to ensure that they leave the facility with a clear set of goals and the information and/or supplies needed to achieve them.
- Integrate contraceptive and birth spacing counseling into maternal health services, including antenatal and postpartum care. Antenatal and postpartum visits often provide the best opportunity to discuss family planning. Research has demonstrated the importance of providing family planning counseling to the mother during pregnancy and in the early postpartum period, as well as ensuring access to contraception, including long-acting and reversible contraceptive methods, as part of developing a life-long reproductive plan.¹¹³⁻¹¹⁴ Maternal health services can be an entry point for reaching young married women and girls in a way that is not threatening to other family members.³¹ An analysis of DHS data from 32 low-income countries found that women who have at least four antenatal visits are **seven** times more likely than those with no antenatal care to deliver at a health facility, increasing their chances of receiving family planning counseling both during antenatal care and postpartum care.¹¹⁵

- Integrate family planning into child health care services. This is an effective strategy for offering young women family planning services at the same time they are seeking other services, such as immunizations for their children. The literature shows that young mothers are more likely to seek health care for their children than for themselves during the postpartum period. Capitalizing on their presence within the health care facility to offer family planning information and a method of their choice reduces their chances of an unintended, closely spaced pregnancy.^{116, 55}

6. Establish supportive laws, policies and systems.

- Establish policies, protocols, and guidelines for discussing contraceptive use during the “interconceptional” period.^d Make a political, economic, and social commitment to reach young first-time mothers and their partners with information, skills, and contraceptive services, since access to and/or use of postpartum care is limited and period of postpartum amenorrhea may vary.¹¹⁷⁻¹¹⁸ New pregnancies are positively associated with a desire to postpone the next birth, and health policies and systems should respond accordingly.¹¹⁹
- Work to establish a legal and regulatory framework that permits all young people, including married adolescents, to access contraception and eliminate non-medical and cultural restrictions around the provision of contraception to young people. Young people too often face policy, cultural, and legal restrictions in obtaining needed contraception. Even when they can access contraception, they may face restrictions in which methods they can access.⁶
- Advocate for policies and regulations allowing young mothers to return to school or to continue their education. For example, in Malawi, the Ministry of Education passed a law in 1993 allowing adolescent mothers to return to school after the birth of a child. Combining a strong policy with community mobilization efforts will help ensure such laws and policies are enforced, and will encourage young mothers to continue their education.⁶⁹

Given the wide variety of both demand- and supply-side factors in determining a first-time parent’s use of contraception, programs which successfully combine a number of approaches to offer an integrated package of information and services for a woman, her partner, and her support network will likely be the most effective in increasing reproductive decision making, use of contraceptives, and better spacing and delaying of additional children.

^d *Interconceptional* is defined as the time period between the end of one pregnancy and the beginning of the next one.

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Appendix I: List of People Interviewed for this Report

Debbie Billings	USC
Claudia Briones	UN Women
Venkatraman Chandra-Mouli	WHO
Nicole Cheetham	Advocates for Youth
Rafael Cortez	World Bank
Wendy Cunningham	World Bank
France Donnay	Gates Foundation
Jeff Edmeades	ICRW/Tesfa Project
Isabel Espinoza	PAHO
Manre Chirtau	EVIA, Tanzania
Rebecca Firestone	PSI
Metin Gulmezoglu	WHO
Gwyn Hainsworth	Pathfinder
Judith Helzner	MacArthur Foundation
Monica Kerrigan	Gates Foundation
Jill Keesbury	PATH
Nicole Klingen	Acting Director, HPN, WG
Elisabeth Lule	World Bank
Suzanne Maman	UNC-CH
Jeff Meer	PHI
Jennifer McCleary-Sills	ICRW
Patricia W. Mosena	Options for Youth
Jane Otai	JHUCCP, Kenya
Sara Pappa	FG
Susan Rich	PRB
Sid Schuler	FHI360
Nirali Shah	PSI
Erin Simes	MacArthur Foundation
Ilene Spiezer	UNC-CH
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Kikelomo Taiwo	EVIA, Tanzania
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