Throughout the Reproductive Life Course: Opportunities and Challenges for Empowering Girls and Women

April 2-3, 2014
Washington, DC

Meeting Report

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The conference and this meeting report were made possible by the generous support of the American people through USAID, under the terms of the Leader with Associates Cooperative Agreement GHS-A-00-08-00002-00 and by USAID’s Office of Population and Reproductive Health, Bureau for Global Health Award Number AID-OAA-A-11-00024.
Executive Summary

The US Agency for International Development (USAID) and the US Health Resources and Services Administration (HRSA) share a common agenda that addresses the reproductive health needs of girls and women across the entire reproductive lifecycle. At a technical meeting co-hosted by USAID and HRSA on April 2-3, 2014, *Throughout the Reproductive Life Course: Opportunities and Challenges for Empowering Girls and Women*, those working for programs supported by these two agencies presented how they are addressing shared challenges: unintended pregnancies; rapid, repeat pregnancies; preterm birth and other adverse pregnancy outcomes; and the need for postabortion care. Both agencies are developing tools and models to reach vulnerable, marginalized, low-income populations, especially to help girls and women make healthy decisions over the entire reproductive life course. Both are supporting research and mobilizing evidence on effective models, approaches, and best practices. Both seek opportunities to disseminate knowledge and share learning opportunities about what works, what does not work, and why.

The meeting was supported by two global USAID-funded projects, Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls (E2A) and the Maternal and Child Integrated Health Program (MCHIP). Presentations at the technical meeting focused on the following six themes:

- Youth
- Using Family Planning to Prevent High-Risk Pregnancies
- Community-Based Family Planning
- Family Planning Integration with Other Health Services
- Multisectoral Family Planning Links with Non-Health Activities
- Integration of Empowerment or Motivational Components

There were a wealth of presentations from international reproductive health programs and several presentations on promising domestic interventions and models. The inclusion of more domestic presentations would add value to the conversation about the continuum of care for girls and women.

Recommendations

Throughout the meeting, many promising approaches were presented; however, some were not supported by sufficient rigorous data and evidence to qualify them as models. Therefore, the recommendations below are based on promising interventions that should be supported by additional research, and tailored and implemented to generate solid evidence of impact.
1. Expand women’s health care to encompass a continuum of care over the life course, and educate women, men, adolescents, and policymakers on the reasons for this life-course approach. At the opening of the meeting, Dr. Michael Lu, Associate Administrator of HRSA’s Maternal and Child Health Bureau, presented the rationale for a continuum of care for women and girls over the life course. He presented evidence of how the biological and cumulative effects of maternal stress lead to adverse pregnancy outcomes—both for the mother and the baby.¹

His research shows that chronic stress is associated with increased risk of preterm birth and infant mortality that is disproportionately higher among African Americans than White Americans (18.5 percent and 11.5 percent respectively).² Based on this evidence, Dr. Lu said that the state of a mother’s physical/mental well-being during pregnancy can contribute to genetic predispositions to certain chronic health issues for the child. In conclusion, he said that to improve maternal and child health, “you start by improving the health of girls and young women.” This can be most effectively accomplished, he asserted, through multisectoral, community-based, economic, educational, and health programs which together can have a collective impact on health and overall well-being (Figure 1). These types of multisectoral, integrated programs, working together, can address the social determinants of health, such as poverty, stigma, gender inequalities, malnutrition, gender-based violence, and unintended and high-risk pregnancies that subject women to stress throughout their lives, and may contribute to poor pregnancy outcomes.

Dr. Hani Atrash, Director of the Division of Healthy Start and Perinatal Services with HRSA’s Maternal and Child Health Bureau, presented evidence on preconception and interconceptional care (interconception is the period after childbirth, but before the next birth) and the importance of reaching women and girls before pregnancy to ensure the healthiest maternal and child outcomes. He observed that early prenatal care is not enough and in many cases too late, and pointed out that critical periods for fetal development are between weeks 5 and 11. The central nervous system, heart, eyes, and other vital fetal organs are all developed during this time (Figure 2). Most women enter prenatal care around the twelfth week of their pregnancy. To fully address the spectrum of care necessary to

¹ Proposing a “cumulative pathways model,” Dr. Lu emphasized that “chronic accommodation to stress results in wear and tear ... on the body’s adaptive systems, leading to declining health and function over time.” He notes that “animals and humans subjected to chronic and repeated stress have elevated basal cortisol levels ... which may lead to immune suppression and immune-inflammatory dysregulation.” Preterm births, for example, may be traced not only to stress exposure and infection during pregnancy, but also to stress and infection (e.g., stress reactivity and inflammatory dysregulation) patterned over the entire life course. (M.C. Lu et al. Closing the Black-White gap in birth outcomes: a life-course approach, *Ethn Dis* (2010) 20(1 Suppl 2): S2-62-76).

support healthy pregnancy outcomes, he recommends comprehensive women’s health across the reproductive life course, which includes preconception and interconceptional care.

2. **Consider reproductive life planning tools to achieve healthy timing and spacing of pregnancy.** The interconceptional care model applied by many domestic programs entails risk assessments, health promotion, and clinical and psychosocial interventions, and includes a Reproductive Life Plan (RLP). The RLP enables clients to set personal goals about having children or not, and helps them to identify family planning methods that will assist them with fulfilling their RLPs. The RLP includes decisions on identifying and achieving fertility goals, using modern contraceptive methods to prevent unintended pregnancy, improving health before becoming pregnant and eliminating risk factors that may affect a pregnancy. The RLP encourages good physical health by addressing nutrition and folic acid, weight, smoking, alcohol and drug avoidance, and oral health. It also addresses mental health, includes a financial discussion on the feasibility of affording a (another) child, and helps the client to identify a social support network. Reproductive life planning uses the time between pregnancies to provide intensive interventions to women who have had a pregnancy that resulted in infant death, low birth weight, or premature birth.

A domestic project operating in Kent County, Michigan, called Strong Beginnings, presented evidence showing that women who made a RLP in Kent County Michigan were much less likely to have rapid, repeat pregnancies (7% rapid, repeat pregnancy rate in the intervention group; 46% in the general Medicaid population) (Figure 3).

The Centers for Disease Control and Prevention, in 2006, recommended RLPs as a way to better use preconception care to improve the health of women and reduce adverse pregnancy outcomes. RLPs have not yet been applied by international reproductive health programs, but we recommend initiating research on this intervention.

3. **Use the interconceptional period to incorporate education on fertility awareness into reproductive life plans both domestically and internationally.** Dr. Victoria Jennings of Georgetown University’s Institute for Reproductive Health hypothesized that the lack of girls’ and women’s fertility awareness can lead to unintended pregnancy throughout the reproductive life course, particularly after childbirth and among older women who assume they are no longer fertile. Research needs to examine the extent to which educating women/men/adolescents about their fertility and increasing their awareness could reduce unwanted pregnancies, misinformation, and incorrect and non-use of family planning. The interconception period, which has been used as a time to encourage women to space their pregnancies in a way that will ensure good health outcomes for mother and child, presents a window of opportunity to address fertility awareness and develop RLPs that encourage

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Figure 3

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<th>Percent of Women Who Experienced a Rapid Repeat Pregnancy (Less than 18 months from birth to conception)</th>
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<td>All Kent County Medicaid-eligible African American women</td>
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<td>Strong Beginnings women who were engaged in the program for at least 18 months</td>
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3 Centers for Disease Control and Prevention, Preconception Health and Health Care, [http://www.cdc.gov/preconception/reproductiveplan.html](http://www.cdc.gov/preconception/reproductiveplan.html).
changes in health behaviors associated with adverse perinatal and birth outcomes.

4. **Expand provision of long-acting reversible contraceptives (LARCs) (both intrauterine devices [IUDs] and implants) during the immediate postpartum period through underutilized channels.** Provider contact with women throughout pregnancy, childbirth, and during the postpartum period was included in several successful postpartum interventions presented at the technical meeting. These interventions show high acceptance of postpartum family planning, including postpartum IUDs. As more countries leverage the immediate postpartum period as an opportunity to initiate family planning, particularly LARCs, the presentations showed that we could see fewer unintended and closely spaced pregnancies, and very likely fewer infant deaths. Presentations showed how postpartum family planning could be expanded through:
   - The private sector
   - Community health workers trained to provide implants
   - Involvement of husbands and mothers-in-law
   - Provision prior to discharge
   - Home visits
   - Provision during infant immunization visits
   - Initiating family planning counseling during antenatal care

   Indeed, the use of contraceptive implants during the immediate postpartum period is a Category Two Center for Disease Control and Prevention Medical Eligibility Standard (i.e. generally use the method) in the United States, where most women give birth in a facility and have a 24-48 hour postpartum stay. Provision of LARC prior to discharge is an intervention that can easily be managed domestically.

   The involvement of husbands and mothers-in-law during the postpartum period is a best practice that has shown a particularly impressive effect on increasing the uptake of family planning. For example, an approach applied by Pathfinder International in Afghanistan reached out to men and mothers-in-law during postpartum counseling. As more postpartum women who were counseled received the method of their choice and their husbands and mothers-in-law were involved in the decision-making process, fewer women became pregnant at 12 months postpartum in the intervention group than the control group (5.8% and 21.9% respectively).

5. **Expand services that link family planning and maternal and newborn health services with non-health and empowerment activities to reduce maternal stress, increase access to services, and improve health outcomes.** A women’s empowerment approach applied by FORSA, a USAID-funded project led by Pathfinder International in Egypt, changed opinions and attitudes about the contribution of women and resulted in greater acceptance of women working outside the home. The project showed, however, that the engagement of men was essential to sustainably improving employment opportunities for women, particularly values clarification and sensitization activities among male stakeholders and gatekeepers. The TESFA project, implemented by CARE Ethiopia, also applied an empowerment model with adolescent girls that combined financial training with sexual and reproductive health education. Adolescent girls engaged through the project enhanced their knowledge about sexually transmitted infections and showed favorable attitudes towards contraception.
Engagement with the non-health sector can also be a powerful approach for increasing access to services and improving health outcomes. Every Woman Southeast, a domestic program that works in multiple southeastern US states, showed how collaboration with non-health sectors such as education, urban planning, media, law enforcement, and faith institutions across the South extended the reach of health centers; in this case, reaching over 10,000 young people to form RLFPs. Programs collaborating with other sectors, such as Education Development Center’s Advancing Youth Project and Population Services International in Liberia, provide evidence linking livelihood training, social and leadership development, and basic career skills to greater uptake of family planning and awareness about reproductive intentions.

6. Use Conditional Cash Transfers (CCTs) with families who meet certain criteria to encourage them to value and educate girls. An approach applied by the Government of Haryana in Punjab, India, gave poor families CCTs when a daughter was born and then another on their daughter’s successful completion of school and delay of early marriage until after age 18. According to an analysis conducted by the International Center for Research on Women, a higher percentage of beneficiary girls tended to complete more years of school compared to non-beneficiaries (p<0.01). The CCT therefore had a positive and significant impact on girls’ education, but there is a need for further analysis about how CCTs can best influence attitudes and perceptions about the value of girls.

7. Improve access to implants at the community level. A program led by Pathfinder International Ethiopia described how Health Extension Workers (HEWs) were supported with a backup system to ensure that they could provide Implanon to communities in a safe and effective way, resulting in the scale-up of Implanon at health posts in Ethiopia. Pathfinder International Ethiopia trained HEWs on Implanon insertion. The HEWs then provided the Implanon at health posts (closer to the community than health centers), and primary health care providers provided backup support to the health posts. Primary health care providers offered Implanon removal and IUD insertions and other family planning services at health posts, bringing a broader family planning method mix closer to the community and resulting in a higher uptake of family planning and reduced travel time for the clients.

8. Undertake research on and test interventions to reach women who may be approaching high parity and advanced maternal age to prevent their entering into these categories of high-risk pregnancies. No abstracts were submitted on these important topics by either domestic or international agencies.

The Reproductive Life Course

The diagram on the following page was created by the USAID-funded E2A Project, which is led by Pathfinder International in partnership with the African Population and Health Research Center, ExpandNet, Intrahealth International, Management Sciences for Health, and PATH. The framework was used as a foundation for the meeting to identify best practices that can be applied and evidence gaps that still need to be filled to improve the sexual and reproductive health of girls and women throughout the life course.
EC  Emergency Contraception
FP  Family Planning
HTSP  Healthy Timing and Spacing of Pregnancy
LAM  Lactational Amenorrhea Method
LARC  Long-Acting Reversible Contraceptive
PM  Permanent Methods
PPFP  Postpartum Family Planning
RH  Reproductive Health
SBCC  Social and Behavior Change Communication
SDM  Standard Days Method
**Introduction**

Two US agencies with common goals—the US Agency for International Development (USAID) and the US Health Resources and Services Administration (HRSA)—were cohosts of a collaborative conference, *Throughout the Reproductive Life Course: Opportunities and Challenges for Empowering Girls and Women*, which joined reproductive health experts from the US and abroad to present practical, high-impact solutions that can be applied to improve the reproductive health of girls and women. The conference was supported by two of USAID’s flagship projects: the Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls (E2A) Project and the Maternal and Child Health Integrated Program (MCHIP).

**USAID and HRSA: Shared Agenda**

The two-day conference, held April 2&3 in Washington, DC, focused on learning from domestic and international reproductive health programs that address the reproductive health needs of girls and women across the entire reproductive life course. The conference was predicated upon the shared focus of USAID, an international government agency, and HRSA, a domestic government agency: the two agencies are working on similar problems in reproductive health including unintended pregnancies; rapid, repeat pregnancies; preterm birth; and the need for postabortion care. Both agencies are developing tools and models to reach vulnerable, marginalized, low-income populations, especially to help girls and women make healthy decisions over the entire reproductive life course. Both are supporting research and working to mobilize evidence on effective models, approaches, and best practices. Both seek opportunities to disseminate knowledge and share learning opportunities about what works, what doesn’t work, and why.

The meeting specifically sought to meet the following goals:

- Disseminate knowledge and identify gaps about effective approaches for empowered decision making throughout the reproductive life course; and
- Explore the use of these findings to strengthen programs, and stimulate new interventions and research opportunities.

**Call for Abstracts**

Prior to the meeting, the organizers issued a call for abstracts (see Annex 1) to domestic and international agencies and providers, and selected 35 abstracts from the 129 submitted which responded to the meeting goals and addressed the following six themes:

- Youth
- Using Family Planning to Prevent High-Risk Pregnancies
- Community-Based Services
- Family Planning Integration with Health Services
- Multisectoral Family Planning Links with Non-Health Activities
- Integration of Empowerment or Motivational Components

**Opening Session**

Four senior representatives from USAID and HRSA—Robert Clay and Katie Taylor of USAID’s Bureau for Global Health and Michael Lu and Hani Atrash of HRSA—opened the meeting.
Robert Clay presented an overview of USAID’s international public health goals, including FP2020, A Promise Renewed—Ending Preventable Child and Maternal Deaths, and achieving an AIDS-Free Generation, and talked about how USAID is working with international and domestic partners to achieve those goals. Katie Taylor spoke about the role of family planning in ending preventable child and maternal deaths, while Michael Lu described the life course perspective applied by HRSA’s Maternal and Child Health Bureau and its importance to the health of the mother and the child. Hani Atrash expanded on emerging approaches to improve pregnancy outcomes in the US, including interconceptional care, the life course perspective, and comprehensive women’s health. He also presented data on racial disparities in perinatal health, and described Healthy Start as a program that is poised to improve pregnancy outcomes in the US.

The Life Course and Meeting Themes

Salwa Bitar of E2A presented the lifecycle diagram, exhibited in the Executive Summary, noting the different stages of the reproductive lifecycle and examples of best practices, evidence gaps that still need to be filled, and drivers of poor health at each life stage. She pointed out that the healthy timing and spacing of pregnancy (a best practice implemented by many USAID-funded programs) and interconceptional care (a main focus of HRSA’s Maternal and Child Health Bureau) were best practices relevant across all life stages and to each of the six meeting themes. The diagram served as a foundation for the meeting.

Throughout the two days, 90 participants, including 50 presenters and moderators, attended the conference. Each of the 10 panel and plenary sessions included presenters from domestic and international reproductive health programs and a moderator with expertise in the technical focus area of the session. The moderator encouraged interactive dialogue with the audience following each panel. At the end of the conference, participants gathered in groups around each of the six thematic areas mentioned above to share what they had learned during the conference, identify research gaps, and explore how to take their new learning and apply it to future programs.

Learning from the meeting including the best practices and evidence gaps shared during the presentations and a summary of the small group discussions are included in this report. At the end of this report, we compile the evidence gaps and give an illustrative list of presentations that responded to those gaps.
Panel Presentations

Theme: Youth

Youth represent a significant proportion of the world’s population, yet the majority of reproductive health and family planning programs are not tailored to their needs. Presentations from domestic and international experiences show that youth have unique needs that vary according to their age, parity, school and marital status, and the general context in which they live. A multisectoral approach that includes youth themselves is imperative to developing effective and appropriate programs. Three sessions were dedicated to youth programming. Panelists in each session expressed the common call for youth-appropriate and youth-driven programming.

Youth Plenary

- **“Again, it’s Abstinence until when?” Unveiling Meanings of Sexual Relationships and HIV Risk in Young Black.** Sithokozile Maposa of the Saskatchewan School of Nursing highlighted the effects that a lack of self-understanding has on a young woman, particularly focusing on how that limits her ability to be in control of her sexual life. She presented a study examining what influences the practical understanding of HIV risk and sexual practices among 12 young African women living in a Midwestern US city.

- **Innovative Approach to Reaching At-Risk Youth with High-Impact Sexual Health Services.** Oby Obyerohyangbo of PATH described the innovative approach applied by Partnership for an HIV Free Generation to mobilize the private sector to offer support for comprehensive services to youth by financing a tele-drama series, offering cash and in-kind support for a talent show, and building a private-public partnership for economic empowerment targeting female youth in informal settlements.

- **Bridging the Gaps: Low-Cost Multimedia Approaches Improve Sexual Reproductive Health & Rights/Family Planning Practices Among Youth in the Post-Conflict Rural Communities of Northern Uganda.** Kenneth W. Buyinza of Plan International Uganda presented a SIDA-funded adolescent sexual and reproductive health and rights project, through which Plan International demonstrated that youth sexual and reproductive health & rights/family planning programs in rural communities succeed with integrated and locally contextualized approaches for behavior change communication, youth who are the change agents, and local health systems that are strengthened to meet resulting demand.

Youth Panel 2

- **Supporting Premarital Abstinence by Fertility Awareness.** Hanna Klaus of the Natural Family Planning Center of Washington, DC described the Teen STAR program, a fertility awareness-based program designed to support premarital abstinence and partner fidelity, which was implemented in Uganda and Ethiopia from 2006-2012. She talked about how girls generally required three cycles to discover their own fertility, while males deepened their knowledge of reproductive and sexual health.

- **Reducing Teen Childbearing Among Hispanics: An Innovative Anti-Poverty Strategy.** Kris Moore, a substitute presenter for Lina Guzman of Child Trends, presented anecdotal evidence which suggests that Hispanic adolescents in the US do
not want to be teen parents, highly value education, and see education as a pathway to improving life chances. Despite these findings, there are few interventions for Latinos in the US that are culturally relevant, and both ineffective and effective programs include the same components, suggesting that the critical differences may lie in implementation.

- **Determinants of Adolescent Premarital Sex in 18 African Countries.** Sitawa Kimuna of East Carolina University presented results from her research in 18 sub-Saharan African countries, which shows a high prevalence of premarital sex among adolescents as well as substantial variations by gender and country in reporting condom use. She therefore recommended that programmers acknowledge the high rates of never-married adolescents who have had premarital sex and design country-specific and gender-appropriate comprehensive sex education programs to prevent sexually transmitted infections and unwanted pregnancies.

**Youth Panel 3:**

- **Improving Reproductive Health of Girls through Girls Room Program in Rwanda.** Alice Bumanzi of the Health Development of Performance Organization described how the distribution of sanitary pads to girls reduces their risk of dropping out of school.

- **Reaching the Most Marginalized: Programming with Adolescent Ever-Married Girls in Amhara, Ethiopia.** Jeffrey Edmeades of the International Center for Research on Women presented how the TESFA project delivered sexual and reproductive health and economic empowerment programming to approximately 5,000 ever-married girls Amhara, Ethiopia. Program participation increased sexual and reproductive health knowledge, attitudes and behavior, particularly in the sexual and reproductive health-only arm. The economic empowerment arm saw greater increases in microenterprise and productive use of savings, while the combined arm saw smaller gains.

- **Innovations v. Sustainability: Exploring Feasible Approaches for Sustainable Youth-Friendly Adolescent Sexual and Reproductive Health Services in Resource-Limited Settings.** Timothy Oboth of Plan International Uganda described how specialized youth/sexual and reproductive health and rights centers are ideal for ensuring confidentiality but are not sustainable. They create dependence, and aggravate social-cultural stigma within the mainstream health system about young people’s sexual and reproductive health; hence, there is a call for development partner projects to explore working within and strengthening established local service delivery structures for young people’s sexual and reproductive health.

- **Paying Girls to Delay Marriage? Evaluation Findings from a Conditional Cash Transfer Program to Delay Marriage in India.** Ann Warner of the International Center for Research on Women led this presentation, which focused on education-related findings: beneficiary girls have higher probability of being in school than non-beneficiaries, even after controlling for other factors. She concluded that conditional cash transfers can be an effective approach to enhancing girls’ education and potentially delaying marriage.

**Panel Discussion**

Discussions following presentations provided further insight into the successes and barriers of youth programming. Three specific themes that arose were gender, disaggregating data, and
fertility awareness. Related to gender, participants questioned how or if programs incorporated young men. Male involvement was mentioned as a priority of HRSA’s Maternal and Child Health Bureau and Healthy Start Program. During the Girls Room Program, Alice Bumanzi pointed out that girls and boys were together during sexual and menstruation education sessions, while other programs, such as the conditional cash transfer program in India, focused only on girls and providing an incentive for parents to keep girls in school.

Regarding the findings from 18 sub-Saharan African countries on premarital sex among young people, participants pointed out that the data need to be disaggregated between forced and consensual sex; in Liberia and Democratic Republic of the Congo, for example, rates of premarital sex were much higher than in other countries, and participants pointed out that this could be because both are post-conflict countries.

Participants asked about fertility awareness programs and their influence on contraceptive uptake. Hanna Klaus pointed out that fertility awareness empowers youth to make their own decisions about the use of contraceptives and naturally results in some young people using contraceptives, although her program did not measure contraceptive uptake.

**Implementation Challenges**

The three challenges facing successful youth programming identified during the conference were gender disparities and socio-cultural barriers, policies that do not support the reproductive health needs of youth, and a lack of rigorous evaluation of youth programs. Gender inequalities increase vulnerability and lead to negative health outcomes for girls and boys. These negative outcomes often stem from a lack of education, early marriage, and early sexual initiation, coupled with limited knowledge, access to and use of family planning. It therefore is imperative to work with communities, religious leaders, and policymakers to promote access to information that is culturally relevant to youth, both in the US and abroad. As highlighted by Timothy Oboth and Kenneth Buyinza, work must be done to educate policymakers on the long-term benefits of youth-focused policies, including contributions to cutting costs, to make them political champions for youth. Policymakers specifically need to understand how it is essential for sexual and reproductive health initiatives to be tailored to young people’s unique needs. And finally, youth programs first need to be evaluated to assess if the program is promoting the change or if the change is happening because of external factors, and then to determine which programs would be scalable.

**Conclusions**

Young people are unique individuals, and one approach or program will not universally work for all youth. Presentations highlighted the need for a multisectoral approach that incorporates youth; for example, by combining economic and reproductive health education and empowerment components. Above all, the conclusion was that youth need to be involved in every stage of programming from beginning to end.

Secondly, gaps in research need to be addressed. A lack of research around certain groups of youth, such as Hispanic youth in the US, must be further investigated to ensure that youth programs are appropriate and effective for a wide variety of youth.

Lastly, several presenters discussed the detriments of sex being a taboo subject. Youth often report feeling unable to talk to their parents or friends about sexual and reproductive health,
which leads to misinformation. There is a need for more analysis on how programs can help influence the ecosystem and cultural norms in which youth live and interact.

**Theme: Using Family Planning to Prevent High-Risk Pregnancies**

High-risk pregnancies—such as adolescent pregnancies, rapid repeat pregnancies, advanced maternal age pregnancies, and high-parity pregnancies—often lead to adverse outcomes for both mothers and babies. It is imperative to reach those in these population groups with effective family planning counseling and services in order to avoid unintended, high-risk pregnancy. The following four presentations comprised this panel.

- **Study on Adolescent Mothers’ Pregnancy Decisions in Bangladesh.** Saleh Ahmed of the Health Service Delivery Project described a study on the pregnancy decisions of adolescents in Bangladesh. Data collected during the study are intended to improve programs to end harmful early childbearing among the study population. The study found that a lack of maternal health services, limited access to family planning, misperceptions about their own fertility, social prejudice, and the socioeconomic context surrounding fertility knowledge were the main determinants of adolescent pregnancies in Bangladesh.

- **Improved Child Spacing Among Low-Income African American Women.** Peggy Vander Meulen of the US Healthy Start Program focused on rapid, repeat pregnancies in Kent County, Michigan, where 46% of African American women became pregnant within 18 months of delivery prior to their program. The program she described contributed to a decrease in the initial percentage to just 7.2% by providing participants with intensive and holistic services through teams of community health workers, nurses, and social workers both during pregnancy and two years following birth. This program utilized strategies that include outreach, case management, and male engagement. The presentation also included a discussion of barriers to family planning and challenge of addressing racism in the provision of family planning services.

- **Introduction of Contraceptive Implants as an Acceptable Method of Life Course Birth Spacing and Reduction of Maternal Mortality in Afghanistan.** Candace Lew of Pathfinder International presented a project that addressed the high fertility and maternal mortality rates in Afghanistan among rural women aged 15-24 and 40-49, as well as the lack of knowledge and use of modern contraception by advocating for birth spacing and birth limiting within an Islamic context. Pathfinder International, with Afghanistan’s Ministry of Public Health and UNFPA, used this approach to conduct a program introducing the long-acting reversible contraceptive Jadelle to the country. Evidence revealed that that population perceives long-acting reversible contraceptives such as Jadelle being an acceptable contraceptive method, particularly for those among the highest at-risk groups.

- **Interconception Care: An Innovative Model to Improve Maternal Health and Future Pregnancy Outcomes.** Lisa Schlar and Jessica Brubach of the Family Medicine Education Consortium presented the idea that interconceptional care is designed to identify and potentially modify behavioral risks to improve future pregnancy outcomes in women. Interconceptional care programs address tobacco use, maternal depression, multivitamin use, and compliance with contraception through the process of having health workers ask potential mothers, who bring in their children, a series of screening
questions. This presentation described how addressing controllable behavioral risks during the interconception period can lead to improved maternal health and birth outcomes and highlighted the importance of provider engagement.

Panel Discussion

Participants emphasized that there are both macro- and micro-level problems associated with high-risk pregnancies, and that birth spacing and preventing pregnancies before age 20 can play an important role in reducing maternal and infant mortality. Participants learned that in Afghanistan, there is a very strong religious (Islamic) influence that weighs on social decisions, especially ones concerning family planning and use of contraception. In Bangladesh, there is a strong push from society for young women to marry and have children. These women have limited educational opportunities and are expected to uphold these social norms. Also, women who feel that they are unattractive believe that if they become pregnant and have a baby, then their husbands will not leave them. We need to work with each unique social and economic context in order to educate different high-risk populations about family planning and contraception.

In the United States, racial inequality is attributable to the large discrepancy in infant mortality among races. African American infants are almost four times as likely to die due to complications related to low birthweight as compared to non-Hispanic white infants. Additionally, as presented during this panel, in Kent County Michigan, 46% of low-income African American women are pregnant within 18 months after last childbirth.

Implementation Challenges

The challenges presented during this panel include conservative attitudes towards family planning, limited access of adolescents to family planning information and services, lack of communication, commodity and supply shortages, provider/workforce shortages in less accessible regions, gender inequality, racial disparities, and a lack of provider engagement and awareness generation.

Conclusions

In order to improve health outcomes for infants, improved health care must be made available to their mothers. For both women who have and have not yet conceived, developing reproductive life plans is important for their own health and the future health of their families. Reproductive life plans have therefore been included as a key component of HRSA’s new Healthy Start Program. Health workers play an important role in the development of these plans. Community health workers, in particular, should be engaged to educate communities about relevant health issues, including the availability of long-acting reversible and permanent methods. Along with providing services, finding ways to empower women to make important decisions about their reproductive health is an important part of this work.

Theme: Community-Based Services

The four presentations in this panel focused on the successes and challenges to community-based programs and activities that seek to influence interpregnancy length and/or intendedness of conception, including improved couple communication and joint/respectful decision making; support to community and religious leaders; and increased access to family planning, including contraceptive implants, through community-based distributors. The panel included multiple
community-based approaches to improve the provision of family planning information and services in four countries: mobilizing religious leaders and men in Senegal, making injectables and long-term contraceptives available at the community level in Zambia and Ethiopia, respectively, and empowering young women to create reproductive life plans in New Orleans.

- **Building Advocates for Family Planning Among Male Leaders in Senegal.** This presentation by Adrienne Allison of World Vision focused on the importance of engaging men in family planning programs when they are the decision makers for the couple’s family planning uptake. To achieve this, World Vision educated Christian and Muslim leaders on the benefits of healthy timing and spacing of pregnancy, and brought civic, religious, and health leaders together to break down barriers and discuss their support for family planning. In 12 months, the contraceptive prevalence rate rose from 2% to 9%.

- **Building on Safety, Feasibility and Acceptability of Community-Based Distribution of DMPA and Implications for Youth.** Jessica Izquierdo of ChildFund International described how the critical shortage of medical staff in many sub-Saharan African countries hinders access to family planning and how the provision of injectables by community health workers can fill this gap. A joint project between ChildFund Zambia and FHI 360 applied this approach, producing positive results in the target community; 35% of the women reported their first DMPA injection as their first use of a family planning method and continuation rates for injectables (63%) were much higher than oral contraceptive pills.

- **Increasing Access to Long-Acting Family Planning (LAFP) at the Community Level: The Pathfinder International Ethiopia Experience.** Kidest Lulu of Pathfinder International focused on a new approach to community-based distribution of long-acting methods in Ethiopia, where health extension workers were trained to insert Implanon and supported with an intervention called “LAFP back-up support.” The program results show major differences in uptake of long-acting family planning (LAFP) in intervention versus control sites (48.5% compared to 22% LAFP uptake, respectively, during the six-month intervention period), indicating that integrating back-up services increases access to and use of LAFP.

- **Map Your Life, Reproductive Health Planning.** In 2013, Healthy Start New Orleans collaborated with the Louisiana Birth Outcomes Initiative, the Birthing Project USA, the New Orleans Fatherhood Consortium, and Title X Family Planning to develop a reproductive health plan known as “Map Your Life.” Kim Williams of Healthy Start New Orleans described this cultural and linguistically appropriate tool that helps women and men of reproductive age explore their readiness to parent, provides evidence-based information on effectiveness of contraceptive options and healthy tips for preconception health, and information on local resources for family planning. To date, the “Life Maps” have been distributed to over 1,000 women and men of reproductive age in the greater New Orleans area and other health care organizations are using the plan.

**Panel Discussion**

Participants emphasized the importance of broadening the family planning method mix to include long-acting reversible contraceptives. They also pointed out the importance of offering contraceptive implants at the community level without jeopardizing the quality of the service, and building the capacity of health facility providers in insertion and removal of long-acting methods at the same health facility, or making them available through backup providers to
community health workers. They also raised the important topic of testing and pre-testing materials and tools in the community before disseminating them widely. Additionally, giving providers appropriate language and messaging they can use with different groups of stakeholders (public health leaders, women) is important.

**Implementation Challenges**

Stock-outs of commodities that hinder the community-based distribution of contraceptives in rural settings, cultural and political opposition which limits access to comprehensive sexual education for adolescent boys and girls, and the integration of family planning services both within and outside health facilities remain a challenge. Additionally, across domestic programs in the United States, public health professionals have expressed difficulty with translating “public health speak” to clients in a way that clients understand and identify with what they are saying.

**Conclusions**

Results of community-based programs include improved couples’ decision making on family planning use, increased use of life planning for young women, increased demand generation, increased accessibility of contraceptive services in the community, and increased uptake of contraceptives. Through the presentations, it became evident that multiple channels are required to mobilize the community to improve life planning, decision making, empowerment, and family planning uptake. The engagement of males and religious leaders in conservative societies, for example, is essential. Bringing contraceptive supplies to the community through outreach workers improves access, especially if supported by backup providers who can manage side effects and complications.

**Theme: Family Planning Integration with Health Services**

In the three sessions, the panelist discussed opportunities to integrate family planning into essential services during childbirth, emergency obstetrical and neonatal care, postpartum care, immunization, diabetes and HIV services, through both public-private partnerships and community health programs. The presentations generally focused on countries where the contraceptive prevalence rate is low. The presenters provided programmatic evidence that family planning use increased when integrated into obstetrical, postnatal, and child welfare services. Interestingly enough, integration of services in the US indicated a keen interest among diabetic clients in nutrition (30%), while many fewer (15%) expressed interest in family planning and screening for sexually transmitted infections. Several presentations addressed the importance of generating demand for family planning through community groups and community health workers, such as in Uganda and Pakistan.

**Integration Plenary**

- **Enabling Private Facility Provision of LA/PMs through an Integrated Model.**
  Stephen Rahaim of the SHOPS project pointed out that despite Bangladesh’s remarkable drop in total fertility rate, from 6.3 in 1975 to 2.3 in 2011, only 8% of couples use long-acting/permanent methods (LA/PMs). He described how LA/PM services were successfully integrated into 35 large private facilities through a carefully designed flexible model to increase their uptake.

- **Trends in Reproductive Health in Russia: Role of USAID-funded Projects and Lessons Learned.** Natalia Vartapetova of the Institute for Family Health in Russia
described how family planning services that were integrated into the full spectrum of client-centered maternal, infant, and child health services improved quality and reduced the number of women receiving abortions.

- **Act Local, Think Global: Applying Systematic Screening to Health Services in Central California.** Irit Sinai of Georgetown University’s Institute for Reproductive Health described how a program in central California applied systematic screening for clients coming in for diabetes services (88% were women) to increase family planning/sexually transmitted infection screening. Among those clients, 30% wanted nutrition and weight management services and only 15% wanted family planning services.

**Integration Panel 2**

Presenters discussed integrating family planning through postpartum family planning at time of delivery.

- **Effect of Family Planning Counseling Provided to Postpartum Women Before Discharge from the Hospital on the Adoption and Continuation of Contraceptive Methods.** Nisreen Bitar of the Health Systems Strengthening II project led this presentation on a study in Jordan, which showed a significant increase of early adoption and use of family planning among women who received postpartum family planning counseling compared to the group that did not (50% and 28% respectively used a contraceptive method within 40 days postpartum). However, within six months postpartum, women are still becoming pregnant, although fewer among the intervention group.

- **Scale-up of Integrated Family Planning and Em Obstetric and Neonatal Care in Uganda.** Salwa Bitar of the Evidence to Action project described how postpartum family planning was integrated into essential obstetric and neonatal care through application of a systematic approach to scale-up called the Improvement Collaborative. The Improvement Collaborative improved the quality of obstetric and neonatal care at 46 health facilities in 10 districts of Uganda and increased family planning counseling from 4% to 62% and family planning use from 0 to 6% in one year.

- **It’s Got Promise! Recent Advances in Family Planning and Immunization Integration.** Trinity Zan of FHI360 presented how immunizers who work to ensure that mothers bring their babies in for immunization present a perfect opportunity to reach mothers with young children on family planning. In this presentation, we see that through this approach, applied in several countries, there was a significant increase in the uptake of family planning without a decrease in immunization rate.

**Integration Panel 3**

- **Lifecycle Considerations in Family Planning/HIV Integration – Findings from a Baseline Survey of HIV Service Clients in Uganda.** Alden Nouga of Pathfinder International presented how among women living with HIV in Uganda, family planning use increased significantly more among women when they heard family planning messages from community groups.
• **Providing Long-Acting Reversible Contraception to Postpartum Women: Introducing Postpartum IUD in Rwanda.** Theresa Hoke of FHI 360 concluded that in a setting like Rwanda it is feasible and acceptable to provide postpartum intrauterine devices through the public sector, but delivery of this service depends on the motivation of individual providers and managers.

• **Integrating Family Planning into Postpartum Care Through Quality Improvement in Afghanistan.** Kathleen Hill of Abt Associates described how the increase in uptake of family planning among postpartum women who received postpartum family planning in Afghanistan is striking when comparing women in the intervention and control groups. Immediate postpartum family planning uptake increased from 12% to 95% in the intervention group within one year after the intervention was initiated. The impact was determined by comparing pregnancy rates 18 months post-childbirth among women in the intervention group and control group; 14% and 35%, respectively.

• **Expanding Community Access to Quality Family Planning Services through Integration and Coordination – The Kasur Model.** Julio Paca on behalf of Tauseef Ahmed of Pathfinder International presented Pathfinder’s project in Kasur district, Punjab, which supported functional integration at grassroots, facility, and district levels to enhance expertise of Family Welfare Centers and involvement of community-based Lady Health Workers to increase demand generation for long-acting reversible contraceptives and referral to Family Welfare Centers for services on a Family Health Days. Within six months of implementation, intrauterine device use rose from 4% to 12%, an 80% increase from past averages for the same period.

**Panel Discussion**

During the panel discussions, participants said that when integrating family planning services into other services there is a continual need for supportive supervision to be tailored to the setting in which the intervention is taking place. Equally important is the use of data to show providers the quality of and gaps in their services. As in the other panels, stock-outs of contraceptive commodities, especially in areas of integrated services, is a common barrier to integration. Privacy issues were also a concern when integrating family planning into non-private services such as immunization or postpartum care on the ward. Partner involvement can increase family planning use, as conveyed during the presentation from Afghanistan, where husbands were contacted on their mobile phones to discuss the benefits of postpartum care for their wives and babies. Similarly, involving mothers-in-law increased family planning uptake. The use of job aids that have been vetted by providers are also helpful. Creating demand for family planning at the community level and making family planning accessible through multiple services are key components to successful integration.

**Implementation Challenges**

One of the significant challenges described by the presenters was the stock-out of contraceptive commodities in integrated services, such as no intrauterine devices in the delivery room for insertion during postpartum care. Additionally, providers who had not traditionally offered family planning services need to be updated on family planning, not only in method use, but also the public health benefit; the use of job aids are helpful. Traditionally, pre-service education for midwives, nurses, and physicians does not include adequate hours for course and clinical family planning practicum. Thus, providers may not fully understand family planning counseling and service provision, especially for long-acting reversible contraceptives, and may need in-service
training. In the private sector, in particular, there is a need to train providers on the provision of long-acting and permanent methods.

Policies both in the US and internationally must permit lower-level health worker cadres to provide family planning, particularly contraceptive implants. Additionally, monitoring of inclusion of family planning into other services increases the likelihood that family planning services will be provided. In busy wards and immunization clinics, lack of privacy issues also hinder women from wanting to discuss their family planning needs. Frequently, women, particularly young women, do not have a voice in their own health care and family planning needs, making it more likely that with the involvement of supportive husbands and mothers-in-law, young women will use family planning.

**Conclusions**

Presenters noted that integrating family planning services where mothers of young children seek services increases their access to family planning information and methods, and, in turn, increases their uptake of contraceptives. Being proactive and reaching out to women, instead of waiting for them to arrive at the family planning clinic also appears to increase family planning uptake. Reaching out to the community through community groups and health workers, for example, increases demand for family planning and is equally as important to developing capacity among health workers in integrated services. Participants noted that when services are combined for the benefit of the mother and baby, there is a decrease in women who become pregnant within 18 months of the last childbirth.

Despite integration and outreach, there are still cultural challenges related to couples desiring large families, and reaching out to young married girls who may not access services prior to becoming pregnant. Involving husbands and mothers-in-law in decision making about family planning and counseling them on the health benefits of using contraceptives therefore increases family planning uptake. Additionally, there needs to be buy-in from providers to integrate family planning into other services, and data from monitoring and evaluating integrated services must be shared with providers to increase their support. Monitoring and evaluation can be conducted during supervisory visits, which are also necessary for successful integration. Policies must also permit lower level cadres of health workers to provide family planning, particularly long-acting reversible contraceptives, and policymakers must demand integrated family planning in health services for youth, and maternal and newborn, immunization, HIV, and community services.

**Theme: Multisectoral Family Planning Links with Non-Health Activities**

Three presentations comprised this plenary session, which focused on integrating family planning information and services with other sectors, including education and faith-based programs and sports organizations, among others, to enhance contraceptive uptake, prevent unintended pregnancies, and improve the health of girls and women.

- **Engaging New Partners to Promote Reproductive Life Planning Among Young Women and Men in the Southeast US.** Sarah Verbiest and Erin McClain of the University of North Carolina’s Every Woman Southeast Coalition presented the coalition’s eight pilot projects that focused on improving reproductive life planning among young women and men in seven southern United States. These projects collaborated with education, urban planning, the media, law enforcement, and faith institutions across the South to reach young adults with interconception health and reproductive life.
planning information and service links. Every Woman Southeast was able to reach more than 10,000 young adults with essential health information and service links by collaborating across multiple non-health sectors.

- **Expanding Access to Critical Family Planning and HIV Services to Low Literacy Youth in Liberia.** Rena Greifinger of Population Services International (PSI) described HealthyActions, a collaboration between PSI Liberia and the USAID-funded Advancing Youth Project that, largely through the engagement of peer health educators, leveraged existing classes for out-of-school 13-35 year-olds with no/marginal literacy and numeracy skills to increase contraceptive use and HIV testing and counseling. Almost 3,000 people were reached. Of those reached, 56% of girls and women began using a contraceptive method and 68% of those reached accessed HIV counseling and testing services. PSI also saw changes in knowledge and behavior related to condom utilization.

- **GenNext: Reducing Adolescent Births in Rural Haiti through Sexual Health Education and Soccer.** Kathryn Kaplan talked about the Haitian Health Foundation’s GenNext program, a positive youth development program focusing on sexual and reproductive health and sports that included education, health screenings, and participation in a soccer league and youth groups. She specifically described the results of a retrospective cohort study in southwest Haiti that assessed birth rates among young women aged 15 to 19 who lived in the villages that participated in the GenNext program in 2006. GenNext saw the potentially protective effect of integrating sexual and reproductive health education and screenings with positive youth development activities, such as participation in youth groups and a soccer league.

**Panel Discussion**

A question raised by the audience for all participants related to measuring impact; that is, not just people reached, but how behaviors are sustained over time. Another issue raised was about gender and empowerment components included in curricula for reaching young people with sexual and reproductive health information, including life planning and negotiation skills. Presenters said impact needed to be measured over an extended period of time, which is often difficult due to time-limited funding. For example, in Liberia, the program is interested in conducting a follow-up evaluation about adherence to short-term family planning methods, generally the preferred choice among the target population, but funding of the project concluded before this evaluation could be done.

**Implementation Challenges/Barriers**

Crosscutting challenges included: implementing sexual and reproductive health projects in conservative environments, where cultural beliefs might hinder the delivery of services; access to sexual and reproductive health services in low-income settings, including infrastructural barriers, and lack of supplies and commodities; gender and power hierarchies that impede women and girls from attaining good sexual and reproductive health; misinformation about family planning and the necessity of developing materials for low-literacy audiences, both for broad reach to populations and to engage peer health educators from those communities; and, finally, the need for sustained funding over a relatively extended period of time to not just reach disadvantaged communities with sexual and reproductive health interventions, but to actually change behaviors, and measure the impact of those behavior changes. Measurement of behavior change is particularly important to determine program effectiveness.


Conclusions

The presentations attested to the power of integrating family planning and other reproductive health information and services for women and girls into non-health programs to increase the use of contraceptives and knowledge about sexual and reproductive health, and to curb unintended pregnancies, particularly among young people. The panelists conveyed that collaboration across sectors can be combined with communication platforms, such as engagement of the media or peer educators, as well as health referrals and screenings, to strengthen sexual and reproductive health among underserved communities, particularly youth.

Through the presentations, it was affirmed that sexual and reproductive health curricula for youth are more powerful with the inclusion of positive and interactive activities and that leveraging existing youth groups/schools to reach young people with information about sexual and reproductive health can be a powerful approach. When designing sexual and reproductive health programs, it was discerned through both the presentations and the moderated discussion which followed that gender-transformative curricula are more effective for improving sexual and reproductive health than curricula that do not seek to transform harmful gender norms. Panelists also expressed the importance of involving target communities in the design of programs and conducting formative research prior to implementation. The audience and presenters acknowledged the continued need to address macro-level factors which contribute to unintended pregnancies and to measure not just outcomes, but impact; to do this, however, both sustained funding and the development of solid indicators for measurement are necessary. Also related to funding, panelists emphasized the need for financing to be flexible in order for health programs to partner with non-health sectors and foster innovative projects in a variety of settings.

Theme: Integration of Empowerment or Motivational Components

This plenary presented a variety of programs with an empowerment or motivational component to address women’s reproductive health needs. The diverse group of panelists shared an array of programmatic experience that contributes to empowerment of women and their reproductive choices.

Presentations covered how fertility awareness increases women’s knowledge on their fertile period, which empowers them to take charge; how the use of mHealth motivated and empowered community health workers and the women they serve; how outreach workers who were young women from rural communities were empowered through capacity building and empowerment activities; and how better interpersonal communication between husbands and wives on sexuality, gender, identity, and family opened up communication and fostered respect.

- **Fertility Awareness May be Critical in Increasing Family Planning Use and Improving Reproductive Health, but Evidence is Scarce.** Victoria Jennings from Georgetown University’s Institute for Reproductive Health presented a systematic literature review that revealed the lack of sexual and reproductive health knowledge among women. Jennings hypothesizes that this lack of knowledge contributes to the non-use of family planning. She suggests that by designing interventions with a fertility awareness component, women can gain this fundamental knowledge and take charge of their reproductive health decisions.
- **Mobile Tools for Family Planning in Benin: “Texting for Maternal Wellbeing.”** Sara Riese of Dimagi Inc. described an operations research study in Benin that used mobile technology to reinforce health messages for community health workers during counseling sessions. A secondary effect of this mHealth family planning project was the motivating and empowering effect on community health workers to meet the reproductive health needs of the women they serve. In the first four months of the intervention, women who adopted a family planning method increased from 13% to 44% when counseled by community health workers using mHealth messages, presenting a promising activity for eventual scale-up.

- **Fostering Opportunities in Rural Southern Areas in Egypt: An Integrated Intervention to Empower Women and Raise Community Awareness about Family Planning/Reproductive Health/Maternal and Child Health Issues.** Julio Paca of Pathfinder International, presenting on behalf of Reem Mehana, presented the FORSA project in Egypt, which established a platform that integrates poverty alleviation, women’s empowerment, and health improvement. Short-term community outreach workers’ jobs were created for young women from rural communities after building their capacities through training on interpersonal communication and counseling skills as well as family planning and reproductive health issues. They were then in charge of raising women’s awareness in their communities about family planning, reproductive health, maternal and child health, childcare, and nutrition issues through household visits. Capacity building and empowerment of outreach workers were assessed quantitatively and qualitatively.

- **Women’s Empowerment Through Inner Spaces Outer Faces Initiative.** The final presentation was given by Suniti Neogy of CARE India. The Inner Spaces Outer Faces Initiative (ISOFI) was designed to share a simple lesson: Every person has both an “internal space” and an “outer face.” Their internal space includes their perceptions of issues such as sexuality, gender, identity, and family. Their outer face represents the way they communicate ideas with others; hence the need to work on both for long-term benefits in sexual and reproductive health programming. ISOFI supported women’s empowerment through counseling visits, establishment of mothers’ committees, and couples counseling. ISOFI aimed to study the impact of this empowerment model on health outcomes.

**Panel Discussion**

There were several questions from the audience to the presenters including those related to the methodology of the fertility-awareness study, financial incentives for participating in the mHealth study, and how community health workers were empowered through their participation, frequency of household visits during the FORSA project, and what tools and culturally sensitive approaches ISOFI had to apply to encourage the communities to participate in “self-care.”

**Implementation Challenges**

There were several challenges identified in the presentations. In regards to Jennings fertility awareness presentation, there is a need to understand how to differentiate between fertility awareness and translating that knowledge into actual family planning use. More knowledge needs to be generated to learn how to take advantage of the gaps in fertility awareness through interventions. Scale-up was a challenge for both the Benin and Egypt programs. In Benin, empowerment was a secondary effect of the intervention. The challenge, in Benin, will be to
scale up the successes of the intervention in a way that exponentially increases empowerment of both female community health workers and the women in their catchment areas. In Egypt, a particular challenge to scale-up is the integration of both men and women. Sustainability is a challenge for ISOFI in India; now that women are able and willing to refuse sex, how can they receive support once the project has ended?

**Conclusions**

Lack of knowledge about sexual and reproductive health, girls’ low school attendance, and gender-based violence contribute to non-use of family planning. Interventions that increase fertility awareness empower women to make and implement sexual and reproductive health decisions. The use of mHealth with community health workers in Benin improved communication and linkages in the health system. Scaling up the approach applied by the FORSA project in Egypt would enhance access to family planning/reproductive health/maternal and child health services among hard-to-reach women, and positively alter men’s attitudes towards women’s empowerment in a sustainable way. ISOFI created an enabling environment by engaging village health and sanitation committee members, improving couple communication, and sensitizing the larger community to women’s empowerment issues through behavior change communication activities, such as Bollywood movie showings and magic shows.
Small Group Work

Participants self-selected a group based on one of the six meeting themes: Youth; Using Family Planning to Prevent High-Risk Pregnancies; Community-Based Services; Family Planning Integration with Health Services; Multisectoral Family Planning Links with Non-Health Activities; and Integration of Empowerment or Motivational Components. Each small group had an interactive discussion reflecting the following questions.

I. What have we learned that we can apply to our work?

**Youth:** Participants concluded that marriage and first pregnancy are the first “teachable” moments for reproductive health in a woman’s lifecycle. Although those moments are important life stages for reaching out to girls and young women, participants said sexual education should start with youth, both girls and boys, as young as 10-14 years old; this time period presents a window of opportunity to change their reproductive health trajectory. Young people must be reached with well-rounded curricula that address not only sexual and reproductive health, but other issues as well, in particular self-efficacy. An enabling environment must be created for good sexual and reproductive health among young people.

**Using Family Planning to Prevent High-Risk Pregnancies:** Participants learned that community health workers can be effectively engaged to educate women and girls in ways that prevent unintended and high-risk pregnancies. Empowerment components and the promotion of long-acting reversible and permanent methods should be included in outreach to women and girls. From several presentations, participants confirmed racism and gender inequality as a stressor to disparate birth outcomes. They mentioned the importance of developing a reproductive life plan and determining pregnancy intention to the provision of family planning.

**Community-Based Services:** Participants learned that successful community-based family planning programs should recognize men as an asset, rather than a liability. They mentioned the need to incorporate empowerment approaches in community services, many of which have not been disseminated widely. As with facility-based services, they said community programs need to reach out to women during the postpartum period with family planning information and services. Participants also agreed that community programs, including those in international settings, should consider the incorporation of reproductive life planning.

**Family Planning Integration with Health Services:** Participants stressed the promotion of healthy timing and spacing of pregnancy in integrated services. Provision of family planning services during post-abortion care was also mentioned as an essential integrated service. To ensure effective integration, existing information and success stories on integrated services need to be disseminated and utilized for the design of future integrated programs. Participants said providers should be engaged with the creation and application of policies that establish an environment supportive of integration, and that any integrated services should ensure that women can access a broad contraceptive method mix. Providers should also follow up with clients using SMS or voicemails.

**Multisectoral Family Planning Links with Non-Health Activities:** Multisectoral work goes beyond reproductive health to other parts of a woman’s life, answering the questions “what do you want to do with your life?” The inclusion of reproductive life planning in multisectoral...
programs could therefore be a powerful addition, although global health programs have yet to apply it. Reproductive life planning, as the group understood it, means checking in with women consistently to measure if women are meeting their life goals in terms of reproduction.

**Integration of Empowerment or Motivational Components:** Participants emphasized empowerment as different for each community and individual. They said it cuts across the life course and different sectors. It matters for people to have an improved quality of life and it matters in terms of results.

2. Where are there gaps in existing structures and how do we close them?

**Youth:** Participants called for more youth involvement in creating policies that govern developing countries. They also pointed out that while we are creating demand for sexual and reproductive health services, we must at the same time be addressing the gaps in supply. Additionally, youth need to be supported to access sexual and reproductive health services despite sociocultural barriers. Youth programming must therefore increase the sensitization and training of health care workers and teachers and engage influential adults in the community as well as parents. Participants said youth should have models and mentors to whom they can aspire. They pointed out the gap that persists in support of married girls and unmarried young mothers, and the huge gap in the implementation of youth-friendly policies.

**Using Family Planning to Prevent High-Risk Pregnancies:** Participants said there need to be models of evidence-based strategies (like the ones recently issued by the US Office of Population Affairs and Centers for Disease Control and Prevention for quality family planning services) that can be applied to curb racism and sexism in the provision of family planning services. There is also the issue of providers not being paid for the services they are asked to offer and value. Among clients, providers’ mistreatment and disparate treatment of patients needs to be addressed. Additionally, ‘well woman’ guidelines and checklists need to be made consistent. Lastly, participants pointed out the imminent need to better identify high-risk women.

**Community-Based Services:** Participants mentioned the lack of reproductive life planning included in community-based programs, which, if incorporated, could make family planning more thoughtful and inclusive of all life choices. They also mentioned the need to both generate demand for family planning services in the community and to improve access to those services. They pointed to pervasive gaps between facilities, the community, and the state, which hinder the effective provision of services. They also mentioned the importance of multisectoral coordination to improve community-based services.

**Family Planning Integration with Health Services:** In terms of integrating family planning with immunization services, participants mentioned that it could be difficult for providers to add additional services to those they are already providing. There are also gaps related to the use of mHealth, including access to phones and information. Models of integration need to be developed, and policy gaps related to the integration of family planning into other health services in certain countries need to be addressed.

**Multisectoral Family Planning Links with Non-Health Activities:** Participants discussed the struggle with defining programs that are truly multisectoral. They said that often many sectors are involved, but they are not really integrated. There is just a lot going on at once. Further research in this area should therefore focus on the design of the program more than the combination of sectors involved.
Integration of Empowerment or Motivational Components: To ensure the incorporation of empowerment components is effective and to measure their effectiveness, programs need time—time that many donors have not allowed. According to participants, five years is not enough time to accomplish and study the desired result. They therefore called for donor flexibility in calls for proposals to allow more time and encourage a balance between conducting research and program implementation.

3. How do we improve programming so that women and children can access quality services throughout the life course?

Youth: Participants said we must first work to understand the wants and needs of youth to be able to address them effectively. To make youth programming sustainable, providers need to be trained and supported to provide services that address the unique needs of different youth groups. Additionally, collaboration with the community is important to build both demand for and acceptance of sexual and reproductive health services for youth. The equity of youth programming must be addressed—by evaluating design and impact to ensure rural populations are reached and by making sure girls are getting quality education. To be more effective, youth programs need to incorporate the life course perspective and capitalize on opportunities for integration with existing services and other sectors, such as schools.

These programs should involve caretakers, mentors, and peer educators. Programmers should also be cognizant of the language used with youth—that it is positive rather than punitive and negative when about sexual and reproductive health.

Using Family Planning to Prevent High-Risk Pregnancies: To improve family planning services in a way that effectively prevents high-risk pregnancies, participants said it was necessary to first determine who the high-risk groups are and then determine the structures of influence. It is also necessary to create multiple access points for education at the community level, to focus on preconception care and to train providers on how to discuss relevant preconception issues with women, and for women to self-identify their needs, in terms of reproductive health and family planning.

Community-Based Services: Participants highlighted the need for flexible, sustainable funding streams; programming that responds to the unique needs of each community; and parameters for sustainability that are defined based on the local context. Men should be engaged early and often, they said. Community-based services should address all six pillars of health systems strengthening, and in particular, the managerial skills—and not just the technical skills—of those leading community programs need to be strong. Participants also stressed the need to educate policymakers on the importance of properly funding and supporting community health programs and developing policies that incentivize community health workers.

Family Planning Integration with Health Services: Participants reiterated opportunities for integration: during the postpartum period and immunization services, during sick baby and well-baby visits from which pediatricians can refer mothers for family planning; in the maternity ward; and within HIV testing and counseling and prevention of mother-to-child transmission of HIV services. They emphasized the need for a system of care and processes, efficiently organized services, and task-sharing. The provision of modern contraceptive methods should be emphasized, with emergency contraception provided at every opportunity. They pointed out that
different models of integration meet different levels of health system capacity, and that not every model is a “one stop shop.” Necessary for integration are government policies that mandate the provision of family planning at all levels of the health system. Providers themselves, if possible, should be the ones to initiate integrated services in order to ensure their buy-in and input from the design stage. Participants also highlighted the need for demand-generation activities at the community level, a strong referral system from community to facility levels, women’s empowerment activities, and the possibility of conditional cash transfers to incentivize family planning uptake.

**Multisectoral Family Planning Links with Non-Health Activities:** Participants said that if we want to reach more people, we have to work with the local systems and we have to find out from the community what works for them. As mentioned above, participants also discussed the inclusion of reproductive life planning in multisectoral programs.

**Integration of Empowerment or Motivational Components:** As mentioned above, participants stressed the need for flexibility with donors, which would allow for funding streams that give more time for the empowerment components to take effect and show results. They also discussed the need to address empowerment uniquely for each individual, and the possibility of engaging with women and children to decide what empowerment would mean for them.

4. **Have you identified opportunities for future research?**

At the beginning of the meeting, Salwa Bitar of E2A reviewed the reproductive lifecycle diagram, which identifies many gaps in research and activities that address the empowerment of women in reproductive health decision making through the various stages of the reproductive lifecycle. The presentations and discussions that ensued confirmed those gaps, while some even began to address them. During the small group work, participants suggested additional evidence gaps to those included in the reproductive lifecycle diagram. This section lists the additional suggested evidence gaps and provides an illustrative list of presentations that address some of the gaps in evidence.

**Youth**

- Male involvement
- Approaches to shift gender norms
- Women’s reproductive health decision making
- Areas of behavior change that have proven effective
- How investing in women through their entire life course vs. only when pregnant affects their self-esteem/empowerment
- Shame around gender-based violence
- How to engage adults appropriately
- What influences the demand for sexual and reproductive health services among youth

**Using Family Planning to Prevent High-Risk Pregnancies**

- How to address and reach women with non-communicable diseases who are potentially at high risk of maternal complications
Community Based Services

- Approaches for successful and sustainable community-based programs
- Opportunities for cross-sectoral collaboration at the community level
  How community health workers can understand and explain how to keep women healthy before pregnancy
- Peer mentorships between high-risk women and community health workers at pregnancy health centers

Family Planning Integration with Health Services

- Equity issues
- How emergency contraception can be more widely available and distributed
- Understanding client preferences through formative assessments and a client-centered approach to integration

Multisectoral Family Planning Links with Non-Health Activities

- Longitudinal studies that work on integrating different sectors
- The design of multisectoral programs (rather than the combination of sectors involved)

Integration of Empowerment or Motivational Components

- Empowering women/parents who then model behaviors

Crosscutting

- Provider bias and comfort with discussing sex
- Referral algorithms converted into apps
- Influencers of demand/supply; barriers to accessing the services demanded

Illustrative List of Presentations that Address Pervasive Evidence Gaps

- Improving Reproductive Health of Girls through Girls Room Program in Rwanda
- Engaging New Partners to Promote Reproductive Life Planning Among Young Women and Men in the Southeast US
- Study on Adolescent Mothers’ Pregnancy Decisions in Bangladesh
- Women’s Empowerment Through Inner Spaces Outer Faces Initiative
- Integrating Family Planning into Postpartum Care Through Quality Improvement in Afghanistan
- Enabling Private Facility Provision of LA/PMs through an Integrated Model
- Increasing Access to LAFP at the Community Level: The Pathfinder International Ethiopia Experience
- Paying Girls to Delay Marriage? Evaluation Findings from a Conditional Cash Transfer Program to Delay Marriage in India
Next Steps

The importance of investing in girls and women over their entire life course, and starting such investments early in the lifecycle came through clearly during the two-day technical meeting. Participants expressed enthusiasm for the new insights and shared learning gained by working with new domestic and international partners. This report documents the evidence presented and key evidence gaps identified during the presentations and discussions that are relevant to both domestic and international reproductive health programs. E2A, USAID, HRSA, and MCHIP (which is now the newly awarded Maternal and Child Survival Program) will continue to pursue opportunities to collaborate and encourage meeting participants and other partners to conduct the future research recommended in this report.
Annex 1: Call for Abstracts

Throughout the Reproductive Life Course: Opportunities and Challenges for Empowering Girls and Women

The United States Agency for International Development (USAID), in partnership with the Health Resources and Services Administration (HRSA), the Maternal and Child Health Integrated Project (MCHIP) and Evidence to Action Project (E2A), will convene a global technical meeting in April 2014 to bring together U.S. domestic and international reproductive health experts to share program learning across agencies. The goals of this two-day meeting are to:

- disseminate knowledge and identify gaps about effective approaches for empowered decision-making throughout the reproductive life course; and
- explore the use of these findings to strengthen programs, and stimulate new interventions and research opportunities.

Background: USAID and HRSA are working on similar problems in reproductive health, including adolescent pregnancies, rapid, repeat pregnancies, and preterm birth. Both agencies are developing tools and models to reach vulnerable, marginalized, low-income populations, especially to help girls and women make healthy decisions over the entire reproductive life course. Both are supporting research and working to mobilize the evidence on effective models and approaches. Both seek opportunities to disseminate knowledge and share learning opportunities about what works, what doesn’t work, and why.

Developing Countries: Nearly 90 percent of the estimated 208 million pregnancies in 2008 occurred in the developing world. Worldwide, 86 million pregnancies were unintended (38%); of these, 41 million ended in abortions (22%). In some developing countries, 40% of adolescents are mothers or pregnant with their first child, while 90 percent of adolescent pregnancies occur within marriage. Pregnancies that are less than 24 months from a live birth increase the risk of adverse outcomes for mothers and babies, both in developing countries and the US. In sub-Saharan Africa, more than 40% of pregnancies are spaced less than 24 months after the last birth. Adolescents (15 to 19 years old) and young adults (20-24 years) have the highest proportion of rapid, repeat pregnancies among all age groups. Advanced maternal age and high parity pregnancies also contribute significantly to the high mortality and morbidity rates found in the developing world. An estimated 222 million women in the developing countries have an unmet need for family planning (FP).

United States: Although the preponderance of reproductive health-related mortality and morbidity is found in developing countries, the US has a relatively high rate of unintended pregnancies, adolescent pregnancies, and preterm births. In the United States, 49% of pregnancies are unintended (unwanted or mistimed). The rate of unintended pregnancy among poor women (those with incomes at or below the federal poverty level) in 2006 was more than five times the rate among women at the highest income level. A 2013 study, conducted in

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the US, found that 35% of the pregnancies in the sample assessed were conceived less than 18 months of a previous birth, and that pregnancies occurring after a short interval were more likely to be unintended..[4] Advanced maternal age pregnancies were found to be growing in number in the US among all ethnic groups and represented about 14 percent of all pregnancies.[5] Domestic agencies have developed tools and approaches that international organizations can incorporate into their programs. Individual abstracts are being accepted for panel presentations, as well as abstracts for preformed panel that highlight healthy decision-making throughout the reproductive life course, including on any of the following topics:

1. **Using Family Planning to Prevent High-Risk Pregnancies.** This includes: adolescent pregnancies, rapid, repeat pregnancies, postpartum or post miscarriage/induced abortion, advanced maternal age pregnancies, high-parity pregnancies.

2. **Influencing Short Intervals and Fertility Intentions.** Successes or challenges of community-based programs and activities to influence interpregnancy length and/or intendedness of conceptions, including improved couple communication and joint/respectful decision-making.

3. **Youth.** This could include: addressing positive youth development, self-esteem, goal-setting, reaching first-time parents, HIV prevention, engaging boys, preventing child marriage, or responding to the needs of married adolescents.

4. **Family Planning Integration with Health Services.** Integrating FP with other health services (e.g., maternal health [antenatal, safe delivery, postpartum care], nutrition services, child health and immunization services, addressing postpartum depression, GBV, or reproductive coercion).

5. **Family Planning Links with Non-Health Activities.** FP linkages with non-health activities (e.g., life skills, literacy, microcredit, income generation, education promotion [keeping girls in school] and skills needed for productive employment).

6. **Empowerment or Motivational Components** Integrated, or holistic FP-MNCH services that include empowerment or motivational components (through use of reproductive life planning and other innovations to overcome barriers to empowerment).

Abstracts must be evidence-based (quantitative or qualitative), with substantive content and no more than 300 words. We encourage colleagues from both the international and domestic spheres to share your work! Individual and preformed panel abstracts will be accepted through February 3, 2014.

Please submit all abstracts to Salwa Bitar at SBitar@e2aproject.org.

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Abstract Submission Form:
Title:
Presenter:
Job Title:
Affiliation:
Theme (select one):  □ FP and High Risk Pregnancy   □ Youth   □ Community-Based Services   □ FP Integration with other Health Services   □ Empowerment Components   □ Multi-Sectoral Approach–FP Integration with Non-Health Services
Geographic Focus of work:  □ USA   □ International

The following sections must total no more than 300 words.
Background:
Methods:
Implementation Challenges/Barriers:
Results and Conclusions:
Annex 2: Agenda

Tuesday, April 1, 2014

All Day
Hotel Check-In and Meeting Preparation

10:00 am – 12:00 pm
Panel Coordinators and Core Team Meeting
E2A Office

By invitation only and via GoToMeeting

Wednesday, April 2, 2014

7:30 – 8:30 am
Breakfast
In Session

8:00 – 8:30 am
Registration
First Floor

8:30 – 9:30 am
Setting the Stage: Domestic and International Perspectives
Chinese Room

9:30 – 9:40 am
Technical Meeting Overview
Chinese Room

9:40 – 11:00 am
Youth Plenary
Chinese Room

11:00 – 11:30 am
Break

11:30 – 1:00 am
Family Planning Integration w/ Health Plenary
Chinese Room

1:00 – 2:00 pm
Lunch
In Session

2:00 – 3:30 pm
Concurrent Sessions A

Community Panel
Chinese Room

Family Planning and High-Risk Pregnancy Panel
Virginia Room

3:30 – 4:00 pm
Coffee
First Floor

4:00 – 5:30 pm
Concurrent Sessions B

Family Planning Integration w/ Health Panel 2
Chinese Room

Youth Panel 2
Virginia Room

Thursday, April 3, 2014

7:30 – 8:30 am
Breakfast
In Session

8:30 – 10:00 am
Multisectoral Integration Plenary
Chinese Room

10:00 – 10:15 am
Emerging Approaches to Improving Pregnancy Outcomes
Chinese Room

10:15 – 10:45 am
Break

10:45 – 12:15 pm
Empowerment Plenary
Chinese Room

12:15 – 1:15 pm
Lunch
In Session

1:15 – 2:45 pm
Concurrent Sessions C

Family Planning Integration w/ Health Panel 3
Chinese Room
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td>2:45 – 3:15pm</td>
<td>Coffee</td>
<td>Virginia Room</td>
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<tr>
<td>3:15 – 4:15 pm</td>
<td>Small Group Work</td>
<td>First Floor</td>
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<tr>
<td>4:15 – 5:00 pm</td>
<td>Presentation of Findings and Closing Remarks</td>
<td>Chinese Room</td>
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Annex 3: Keynote Speakers

Robert Clay, Deputy Assistant Administrator, Bureau of Global Health, USAID. Senior Foreign Service Officer, when Robert Clay joined USAID in 1983, he was responsible for expanding the Agency’s efforts to increase oral rehydration therapy worldwide. Since then, he has served the Agency in positions including: Director of the Office of HIV/AIDS, where he was responsible for leading the Agency’s programs under the President’s Emergency Plan for AIDS Relief; Director of USAID’s Population, Health and Nutrition (PHN) Office in India; from 1998 to 2003, Director of the PHN Office in Zambia, where he led the development of one of the first multisectoral HIV/AIDS programs at USAID; Chief of the Health Services Division in the Bureau for Research and Development; and Deputy Director of the Office of Health and Nutrition in Washington, DC.

Katie Taylor, Deputy Assistant Administrator, Bureau for Global Health, USAID. Previously, Katie Taylor served as the Executive Director of the Center for Interfaith Action on Global Poverty (CIFA). She also worked for General Electric for nearly 20 years in a wide variety of businesses, including its health care, transportation, and mortgage units. Before joining CIFA, she was Vice President for International Business Development at the University of Pittsburgh Medical Center. A multilingual executive, she has lived and worked in the Americas, Europe, the Middle East, North Africa, and Asia. She has a BA in political science from Yale University, a graduate Certificate of Political Studies from Institut d’Etudes Politiques de Paris and an MS in international business from Georgetown University.

Michael Lu, Associate Administrator, Maternal and Child Health Bureau, HRSA. Dr. Lu joined HRSA from the University of California, Los Angeles (UCLA) Schools of Medicine and Public Health, where he was associate professor of obstetrics, gynecology and public health. Dr. Lu brings years of experience in maternal and child health research, practice, and policy to his post at HRSA. Prior to his appointment, Dr. Lu chaired the Secretary’s Advisory Committee on Infant Mortality. He has served on two Institute of Medicine (IOM) Committees (Committee on Understanding Premature Birth and Assuring Healthy Outcomes, and Committee to Reexamine IOM Pregnancy Weight Guidelines), and the Centers for Disease Control and Prevention Select Panel on Preconception Care. While at UCLA, Dr. Lu was best known for his research on racial-ethnic disparities in birth outcomes, and his visionary leadership on life course. Dr. Lu has received numerous awards for his teaching, has attended over 1,000 births, and has been voted one of the Best Doctors in America since 2005.

Hani Atrash, Division of Healthy Start and Perinatal Services, Maternal and Child Health Bureau, HRSA. Prior to joining HRSA, Dr. Atrash was at the Centers for Disease Control and Prevention (CDC), where he served as the Chief of the Pregnancy and Infant Health Branch from 1987 to 2001, Associate Director for Program Development of the National Center on Birth Defects and Developmental Disabilities from 2001 to 2008, and Director of the Division of Blood Disorders from 2008 to 2012. During his distinguished public health career, Dr. Atrash has served as faculty at the American University of Beirut, where he also received his medical training; a consultant for the World Health Organization and several other international groups; and has led CDC efforts around safe motherhood, maternal and child health epidemiology, and preterm delivery. He spearheaded the new CDC initiative on Preconception Health and Health Care. Dr. Atrash received numerous CDC and national awards and authored/coauthored over 170 scientific publications and book chapters.