Background
Today, more than a quarter of the world’s population is between the ages of 10 and 25. This cohort of 1.5 billion people is the largest ever to come of reproductive age. Hence, there is a demographic imperative to motivate this generation to adopt healthy childbearing habits—including healthy timing and spacing of pregnancies. Moreover, although adolescence is a period of experimentation and risk, studies show that young people are “the greatest potential force for change if they can be reached with the right interventions” (Roeland et al, 2006).

Spacing Saves Lives
There is strong evidence that healthy timing and spacing of pregnancy saves lives from six key studies conducted between 2000 and 2005 (supported by USAID). These studies indicate the lack of appropriate spacing significantly harms maternal and child health. Birth-to-pregnancy intervals of less than six months were associated with a 150% increased risk of maternal mortality. Risk of induced abortion was 650% greater, and miscarriage 230% greater among women with short intervals. Child health was also adversely affected, including a 223% increased risk of newborn death.

WHO convened a panel of technical experts to review the findings of these six studies (WHO, 2006). As a result of this review, the panel made the following recommendations:

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

Given the clear benefits of spacing pregnancies, how can health communication programs help ensure that these recommendations are widely disseminated? What are the lessons learned in motivating mothers and communities to adopt safe birth intervals?

Strategies for motivating young women and the communities around them: insights from three countries
Studies conducted in 2007 by in Jordan, Uganda, and Egypt by the Health Communication Partnership (HCP) illustrate how health communication approaches can help change community norms and promote birth spacing.

“...so we could help each other in providing for our children and I too could work....”
-Young Woman, Jordan

Jordan and Uganda
In each country, 12 focus group discussions were conducted among women and men of reproductive ages who had at least one child below the age of five to understand social norms and perceived barriers to birth spacing (HCP, 2007). Despite different settings in Jordan and Uganda, the studies revealed similar findings, including:

- Child bearing is the number one expectation for and by couples. Therefore, couples are pressured to start childbearing immediately after union.
- Birth spacing is not a new concept. The traditionally or religiously sanctioned spacing is two years (birth to pregnancy in Jordan, birth to birth in Uganda). Ugandans even have derogatory terms for women with too short or too long birth intervals.
- Birth spacing is acceptable. Family planning is more problematic. Society condones the concept of spacing births. Family
planning, however, is often perceived as determining the number of children a couple will have, which conflicts with some religions.

- Barriers to births spacing include family and community pressure, desire for male heirs, woman's late age at marriage, and poor knowledge of contraception and fear of side effects.
- Motivators for spacing births include high cost of living, desire for attention to each child, mother and child health, and better quality of life for the couple.

In addition, the studies confirmed that family and friends are the main sources of information about birth spacing. Health providers are rarely consulted. Thus misleading information often circulates widely. Respondents suggested various strategies to communicate appropriate birth spacing information—particularly entertainment-education such as radio and TV series, soap operas, testimonials, talk shows, and other entertainment formats. Other suggestions concerned policies, the educational role of health providers, and improving the quality of services.

**Egypt**

Using data from successive Demographic and Health Surveys (1995, 2000, and 2005), HCP researchers found that Egypt is going through a generational shift as more women are becoming “expert” spacers, initiating family planning after the birth of the first child, and even within 40 days of delivery. Safe extended spacing between births has become a norm. Moreover, today’s unmarried youth are more likely to have positive attitudes than earlier generations, such as approving family planning after the first child or endorsing one or two children as the ideal number to have (Storey et al. 2007).

These key norms concerning family size limitation, early initiation of family planning, and birth spacing strongly correlate with contraceptive use. Also, they were consistent with messages promoted by the National Family Planning Program. Data also showed that shifts in norms over time were correlated with change in the emphasis of the national family planning communication program from small family size to birth spacing. Such analysis demonstrates that societies can shift social attitudes and behaviors about birth spacing through the use of strategic communication.

**Global video conference on changing norms for health spacing of pregnancy**

In December 2007, participants from Kenya, Geneva, Uganda and the United States, joined in a virtual meeting broadcast over the internet to share insights and findings. In addition to the data mentioned above, Sheikh Hussein Mahad from Kenya addressed the role of religious leaders. In his experience in rural Kenya, religious leaders are willing to play a catalyzing role to address maternal and child health issues. The Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP) has also found that religious leaders are indeed interested in promoting birth spacing with communities such as in Guinea, Jordan, and Senegal.

Discussions from the video conferences emphasized that programs should be in tune with what couples and elders think and say about birth spacing. Programs should be mindful that in many societies “the first baby belongs to the community” and that spacing is more acceptable after the first child. The entire community benefits from the good health of mothers and children. Working with all stakeholders can help improve the supportive environment and increase adoption of birth spacing as the social norm.

**Conclusions**

While the research from Jordan, Uganda and Egypt indicate that family and social pressure can be major impediments to safe birth spacing, it also suggests that effective communication can overcome these pressures and promote healthy timing and spacing of pregnancies as the social norm. Programs, such as the experiences in Egypt and Kenya, should continue to pursue ways to engage local cultural, political, and religious leaders to promote birth spacing and seek out the best ways to work with the community.

**References**


*WHO is continuing to review the evidence on pregnancy intervals and health outcomes, and will issue supplemental guidance when their review is completed.*