

# Taking advice from those they trust: Traditional Birth Attendants as family planning promoters and providers in rural Guatemala

Final report executive summary

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IRH was awarded the 5-year Fertility Awareness-Based Methods (FAM) Project by the United States Agency for International Development (USAID) in September 2007. This 5-year project aims to increase access and use of FAM within a broad range of service delivery programs using systems-oriented scaling up approaches.

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**The FAM Project**

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## Executive Summary

In Guatemala some 153 of 100,000 live births end with maternal mortality, caused in part by low contraceptive use and inadequate birth spacing. Traditional Birth Attendants (TBAs), or comadronas in Guatemala, are respected Mayan women who attend births but remain untapped resources for family planning (FP). Until now, Guatemala's Ministry of Health (MOH) believed training TBAs to offer FP was unfeasible due to their age, cultural taboos and the logistics involved in offering FP outside health center settings. This is common practice in many other countries where community workers are available to support health promotion and service delivery but are not included in formal health service programs. However, it is a proven High-Impact Practice to train, equip and support community workers to provide a wide-range of contraceptive methods. Community workers, such as TBAs in Guatemala, can help address barriers to access FP services by bringing information, services and supplies to women and men in their communities.



In partnership with the Guatemalan MOH Department of TBAs, Georgetown University's Institute for Reproductive Health designed, implemented and tested a strategy for delivering FP through TBAs. The intervention aims to enable TBAs to promote all FP methods; offer four methods: oral contraceptives, condoms, Standard Days Method (SDM) and Lactational Amenorrhea Method (LAM); and refer for other methods. The strategy included several components:

- 1) Training TBAs to promote and provide FP methods;
- 2) Connecting TBAs with auxiliary nurses who train and supervise them;
- 3) Supplying TBAs with commodities; and
- 4) Linking TBAs to the reporting system of the MOH's central Management Information System (MIS).

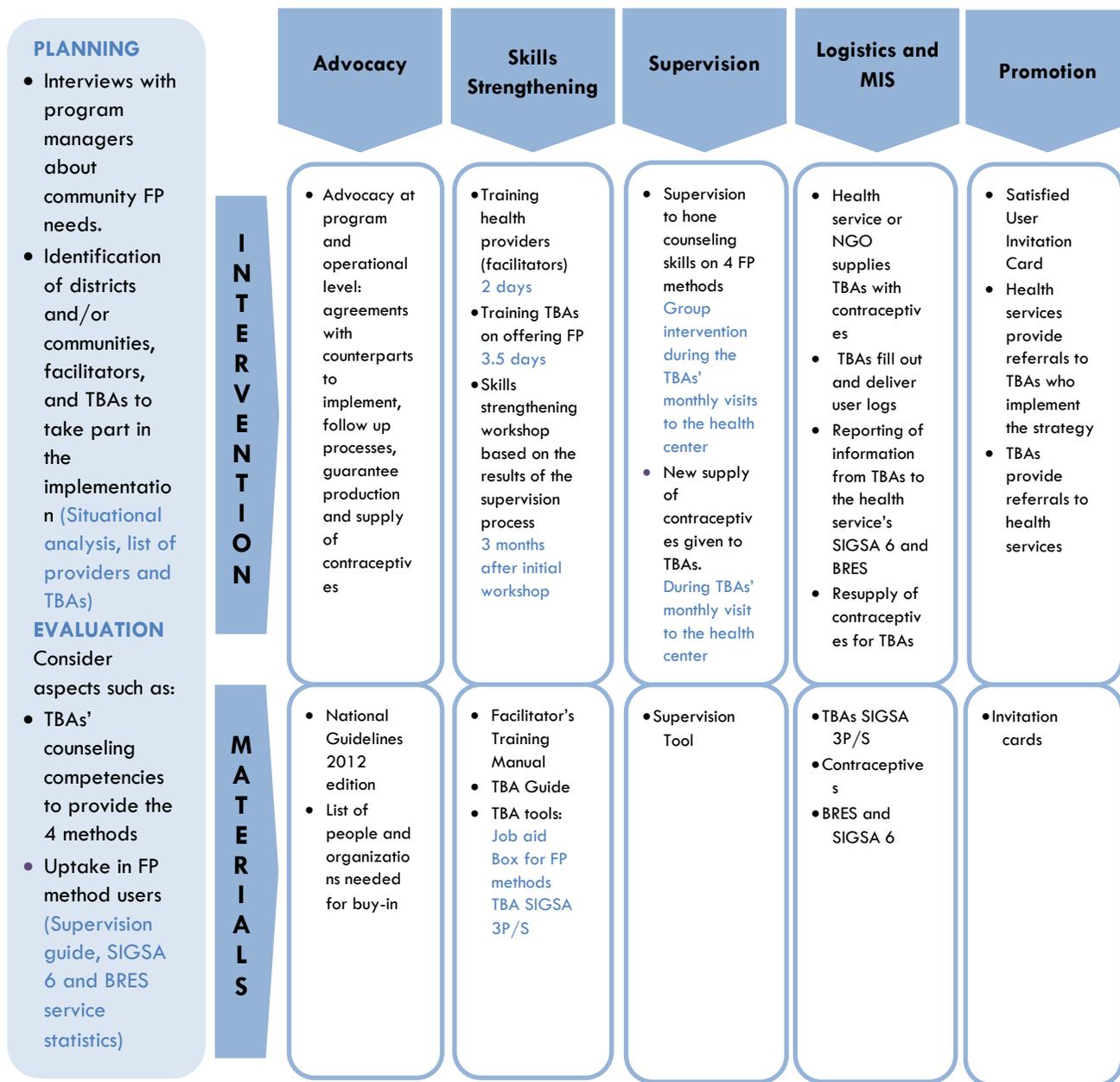
### Strategy design

To determine how to work with TBAs, formative research was conducted to develop a training methodology that builds on the existing experience that TBAs have as birth attendants and create materials to strengthen TBAs' skills in providing FP services in a community setting. Based on these findings, low-literacy pictorial job aides and training materials were developed. A low-literacy recording form was also developed for TBAs to record FP users and to help them track future resupply of methods.



Figure 1. On left: TBA Guide for Family Planning in the Community; on right: Facilitator Training Guide.

# Traditional Birth Attendants Strategy Diagram



## Implementation

The MOH identified the municipalities of San Juan Ostuncalco and Colomba Costa Cuca in the department of Quetzaltenango and the municipality of Casillas in the department of Santa Rosa as the sites for implementing the strategy. Advocacy and orientation activities with the municipalities and TBAs followed.

Building the capacity of TBAs included training them on FP promotion for all methods and counseling and service delivery for the four methods they would offer, as well as record keeping and referrals for other methods or any health issues they encounter. A cadre of auxiliary nurses were trained as facilitators to conduct training sessions for TBAs. In total, 85 TBAs were trained by 22 trained facilitators. TBAs also received on-going supervision from auxiliary nurses for the health centers they were assigned to.

**TBA Profile**

Age: 23 to 87 (median age = 46)  
Gender: Mostly female (two male TBAs)  
Ethnicity and language: Mayan (Mam, Kaqchikel) & Mestizo (Spanish)  
Communities: Rural and peri-urban  
Education level: No formal schooling to completing primary-level school  
Role in communities they live in: Attending births, pre and post natal care, and providing information on health issues (as provided to them by the MOH)

**Monitoring and evaluation**

Key indicators were identified to determine how well the strategy contributed to strengthening knowledge and developing skills among facilitators and TBAs, as well as the strategy’s overall acceptability, feasibility and sustainability. For the supportive supervision of TBAs and for monitoring quality of counseling provided, a competency checklist was used three months after the TBA orientation by facilitators. A reinforcement workshop was provided on the basis of its results.

The evaluation components of the strategy included focus groups with TBAs (29), in-depth interviews with health coordinators and program managers (12), application of the competencies checklist

with TBAs (29) and service statistics for control and experimental areas, before and during the intervention’s implementation.

**Results**

**TBAs’ competency**

The application of the competency checklist showed that the majority of TBAs know the medical eligibility criteria and essential messages for all four methods, but that some additional efforts were needed to strengthen knowledge on counseling for LAM and oral contraceptives. Meanwhile, 72% knew how to correctly explain condom use and 79% could accurately apply the criteria for SDM use. In general TBAs also identified Healthy Timing and Spacing of Pregnancies.

**Table 1. Knowledge of essential information for each method.**

Method	% of TBAs (N=29)
LAM	62%
SDM	79%
Condoms	72%
Oral contraceptives	59%

### Acceptability and feasibility of strategy

Both program managers and TBAs found the strategy acceptable as an intervention that makes FP more accessible in rural communities. Specifically, they stated that it empowers TBAs to approach men and women in their communities with information and services in their own language, with less time restrictions than clinic-based health providers, and in a culturally relevant manner. However, program managers also mentioned some factors that limit the strategy's feasibility, including resistance from local health centers to adopt new processes and increased workload (e.g. time of auxiliary nurses to work with TBAs, merging information from TBA reporting forms with clinic reports, etc.). Additionally, some health providers see TBAs having difficulty understanding the process to resupply methods and record-keeping, which TBAs also admitted to.

### Demand for family planning

Service statistics obtained from the MOH helped shed light on changes to FP demand before and during the intervention, as well as in the experimental and control areas. While TBAs kept their records of new users, data was compiled at the district-level health area. As a result service statistics presented here include reported new users from clinic providers at service delivery points (SDPs) and TBAs combined, when referring to the period of intervention. Figure 2 shows an increase in FP demand in the experimental area during the intervention as compared to prior to the intervention. Meanwhile, Figure 3 shows that there was also increase in the control area over this timeframe. Figure 4 illustrates the number of commodities dispensed by TBAs in the community and providers in clinics in the intervention areas.

These results show that the strategy has the potential to help increase demand for family

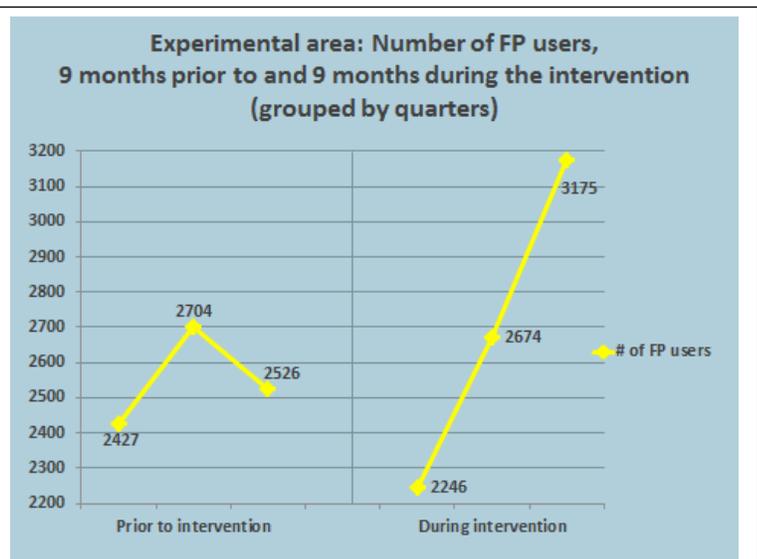


Figure 2: New FP Users from SDPs and TBA in experimental area, prior and during the intervention

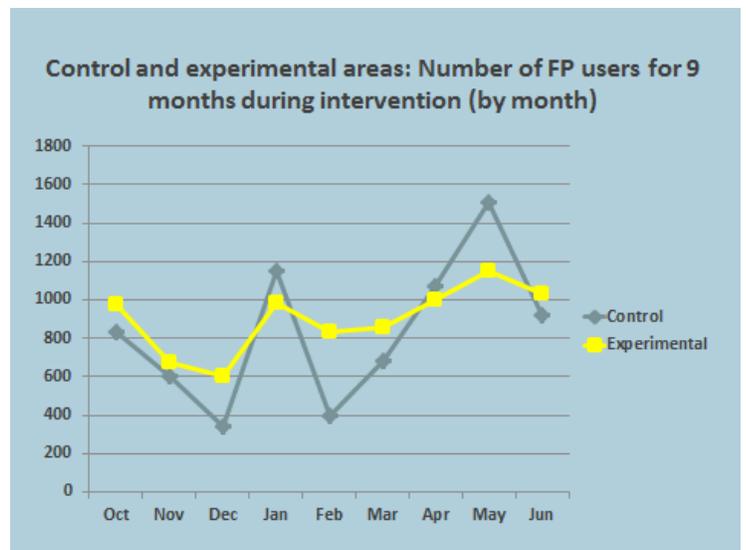


Figure 3: New FP users from SDPs and TBAs in control and experimental area, during intervention

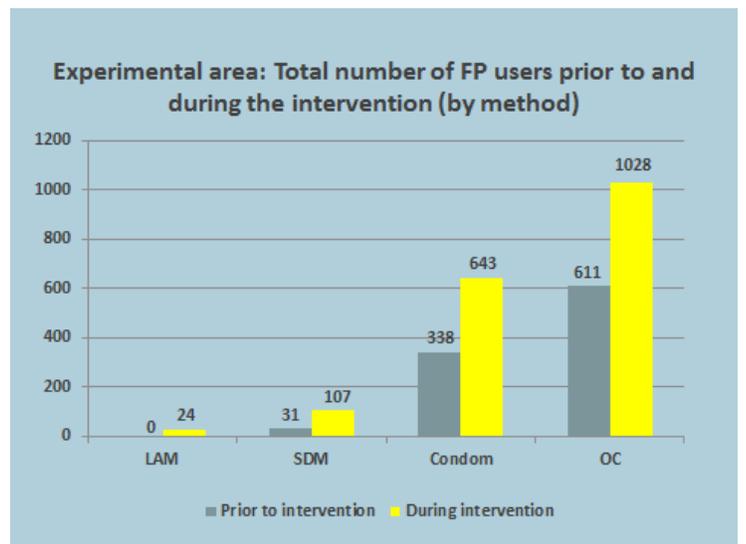


Figure 4: New FP Users for SDPs and TBAs, during intervention, by method

planning methods and to help expand supply and access, especially at the community level.

### **Conclusions**

Program managers, facilitators and TBAs expressed that the strategy has important benefits for the community, but that it requires an investment of human resources and funds to continue operating. Decisions about further investments in this strategy will determine its continuation and expansion in the future. Other observations and recommendations include:

- TBAs can be agents of change when supported by programs. They can help improve access to family planning methods within communities.
- Involvement of the MOH is key to expanding access to FP to rural areas not reached by clinic-based services.
- There is a need to improve TBAs' skills in handling FP MIS and logistics. Consideration should be given to having the logistics personnel in the health area be involved in the facilitators' workshop to be aware of the process and adapt distribution and MIS to the TBA strategy in their district.
- The supervision instrument should be applied consistently on a quarterly basis during the first year to identify weaknesses to be improved during meetings or workshops.
- Expansion of the strategy would involve health areas integrating the strategy into their work plans and budgets for its sustainability, including conducting orientation workshops and distributing materials for implementation.
- Since TBAs expressed feeling a lack of recognition for their contributions to FP service delivery, providing a stipend for TBAs, who are currently unpaid, may serve to recognize their efforts and time and maintain their motivation.
- Due to the fact that the intervention and evaluation time frame were brief there was no time to work with TBAs on referrals and strengthening this component of the strategy.
- It would be beneficial to carefully track referrals by TBAs and for this information to be isolated from service statistics of clinic providers, in order to assess TBAs contribution to increasing FP access and demand.

### **Resources:**

[TBA Facilitator's Manual](#)

[TBA Guide](#)