

Assessment of the use of a Lactational Ammenorrhea Method (LAM) User Card to Improve Recording of this Family Planning Method in Ministry of Health Clinics in Sololá, Guatemala

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Acronyms

APROFAM	Asociación Pro Bienestar de la Familia Association for the Well-Being of the Family
DAS	Dirección de Área de Salud Health Area Directorate
ENSMI	Encuesta Nacional de Salud Materno Infantil National Survey of Maternal & Child Health
FP	Family Planning
HTSP	Healthy Timing and Spacing of Pregnancies
IEC	Information, Education and Communication
IRH	Georgetown University Institute for Reproductive Health
LAM	Lactational Amenorrhea Method
MOH	Guatemala Ministry of Health
SIGSA	Sistema de Información Gerencial de Salud Health Management Information System
SRH	Sexual and Reproductive Health

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Executive Summary

Background

The Lactational Amenorrhea Method (LAM) is a modern and effective method of family planning (FP) for postpartum women, based on the natural effect of breastfeeding on fertility. In Guatemala, LAM is included in the National FP Guidelines of the Ministry of Health and Social Assistance (MOH), as well as the guidelines of FP organizations such as APROFAM and NGOs that provide FP services. However, despite providers' familiarity with LAM and its inclusion in policies and norms, few health centers inform clients about LAM or offer it to women in prenatal checkups, birth and postpartum. As a result, few women have heard of and/or use LAM.

According to the recent National Survey of Maternal and Infant Health (ENSMI) 2008-2009, only 4.6% of women have ever used LAM in Guatemala, which pales in comparison to the percentage of women who ever used a modern method of FP (66%). At the same time the ENSMI indicates that half of children aged 0-5 months are exclusively breastfed, which may indicate that a substantial proportion of women are exclusively breastfeeding, yet are not practicing LAM. Additionally, there is also confusion among providers and users alike regarding the criteria for LAM; many users and providers equate exclusive breastfeeding with LAM use, resulting in inaccurate over-reporting of LAM by providers.

In 2010 and 2011, the Institute for Reproductive Health (IRH) at Georgetown University introduced LAM user cards in Mali, India and Democratic Republic of Congo as part of the Fertility Awareness-based Methods (FAM) Project, funded by the U.S. Agency for International Development. In all three countries, LAM user cards were used during counseling sessions with providers and anecdotal evidence suggested the cards improved LAM counseling, resulting in better recall of the method's three criteria. Improvements in recording and reporting of LAM users were also noted.

Of the three departments in Guatemala (Quetzaltenango, Solola and Santa Rosa) where IRH is lending technical assistance for scale-up and integration of FAM, the MOH chose Solola for this study. LAM makes sense in the context of Solola, where indigenous communities have strong religious, mostly Catholic, belief systems and a long tradition of using natural medicine, as well as high rates of breastfeeding.

Study Methodology

This research examines the development, introduction and use of a LAM user card designed to: 1) improve reporting of users, 2) increase provider and user knowledge of LAM criteria and 3) facilitate the transition to other FP methods.

Through provider and stakeholder interviews and a review of monthly service statistics, the study sought to determine if the LAM user card makes a difference in provider and user knowledge of LAM, including when to transition to another FP method, as well as correct recording of LAM users in Guatemala. A quasi-experimental study compared LAM counseling with the LAM user card (experimental group) to counseling using only the MOH LAM brochure (control group), which is the standard of care in Guatemala. This study consisted of three stages:

Stage 1: Three-hour training in LAM for providers in control and experimental facilities. The control group received training using the MOH LAM brochure and the experimental group received the LAM user card to give to users, as well as the MOH LAM card.

Stage 2: Baseline assessment conducted after introduction of the LAM user card, to gauge provider knowledge and use and reporting of LAM in control and experimental facilities. Baseline interviews with stakeholders were conducted to assess value of LAM, perceptions on provider acceptability and issues around reporting.

Stage 3: Final assessment conducted six months after the baseline assessment to compare the differences between the two groups in knowledge, understanding, use and reporting of LAM. Endline interviews with stakeholders were conducted to assess changes in perceptions evaluated during baseline interviews.

Results

Stakeholder interviews

At baseline most stakeholders felt LAM had multiple benefits, including that it encourages optimal infant nutrition through breastfeeding, it does not require a commodity, and it gives new mothers time to choose another FP method after childbirth. However, some also mentioned disadvantages to offering LAM, namely that it “takes more commitment and communication [by providers]” and that “[users] have more difficulty using it” compared to other methods. At baseline stakeholders mentioned that the MOH uses different and somewhat confusing forms, still in circulation in many areas, where LAM is grouped together with all other “natural methods.” However, at endline stakeholders said that providers were recording LAM users in the appropriate forms.

At baseline, most stakeholders who had seen the user card felt it would be beneficial and practical for demonstrating how to use LAM, and would also serve as a reminder for users to keep track of appointments and the three criteria. These positive opinions were also seen at endline, where stakeholders described the card as useful, of good quality and easy to use.

Initially, stakeholders expressed concerns about the high cost of printing the user card and the lack of a system to purchase or procure cards. One solution suggested during baseline interviews involved including the cards in the MOH operational budget for the upcoming year. Stakeholders

also shared concerns regarding provider bias against LAM. At endline, central and department-level stakeholders were in favor of supporting the continued use of the card, but program coordinators expressed doubts that decision-makers would follow through on their promises. Stakeholders said providers had misperceptions about LAM, such as that it is equivalent to breastfeeding, less “modern” than other methods or less effective than other methods. At endline however, stakeholders pointed to bias from users instead of providers as a barrier for LAM integration into health programs.

Provider interviews

At baseline providers mentioned advantages and disadvantages of LAM citing that it is natural, easy to use, effective, supports birth spacing and may be a low-cost FP option, but that there is also difficulty in using the method among women who work outside the home, it has a short duration of use and there’s lack of protection for sexually transmitted diseases – even though this applies to most methods. Providers also mentioned that some women reject natural methods and distrust LAM because they think other methods are more reliable.

Encouragingly, at endline few providers from both the control and experimental facilities reported that breastfeeding and LAM are equivalent. Overall, knowledge of the three LAM criteria was high but was slightly higher in the control facility than the experimental facility.

In both the experimental and control facilities, more than three-fourths of providers stated at endline that they had offered LAM in the previous three months. Although slightly more providers mentioned offering LAM in the control group, more providers in the experimental group mentioned offering LAM during prenatal and postpartum visits. Results also showed that by endline the control group always used the MOH LAM brochure during counseling, and the experimental group continued using the MOH LAM brochure in addition to the LAM user card. Providers in the control group did slightly better than those in the experimental group at correctly identifying all three instances when LAM users should transition to another method of FP. Knowledge of when to transition to another method was higher in the experimental group at baseline, but decreased at endline.

At baseline and endline providers in the experimental group were asked about their use of the LAM user card and the availability of the card. At endline, the percentage of providers using cards during LAM counseling had increased to 78% and the amount of women who were given LAM cards also increased. However, the availability of LAM cards only increased slightly to 65%. In some cases, low use of the LAM card may have resulted from inadequate distribution of the card during the study period, lack of LAM training for new providers or lack of awareness that the MOH authorized and endorsed use of cards in clinics.

In relation to recording LAM users, at baseline few providers noted ever recording LAM users or recording users in a daily register, possibly because they were using old versions of the SIGSA.

However, at endline the percentage of providers who registered a LAM user was 70% or higher in both the experimental and control group. Daily registry of LAM users was also high at endline. Both indicators, however, were higher for control group providers.

Service statistics

Service statistics were obtained for the control and experimental areas for an eight-month period prior to the distribution of LAM cards and after LAM cards were distributed. Results showed a slight increase in LAM users from at the start of the study period and then at end of the study period, however, in the middle months there is a significant increase in LAM users in the control group. A number of reasons could explain this increase in the control group, including staffing changes in the experimental area and stock out of LAM cards, both mentioned by stakeholders as problems faced in the experimental area during the study.

Conclusion and Discussion

Some general and specific conclusions can be drawn relevant to the future integration of the LAM user card in Guatemala:

- Most stakeholders value LAM as a FP method, but reported that provider bias against LAM was a major barrier. Efforts are needed to strengthen understanding of LAM and improve provider capacity to counsel and register LAM users.
- Stakeholders considered the LAM user card a practical and feasible approach for improving LAM recording and knowledge among users and providers, however, concerns remain regarding reproduction costs and government commitment to providing the cards.
- Stakeholders, including an SRH advisor, and some health providers stated they were not familiar with the LAM user card, “had no mandate from the MOH to implement the card” and/or “were not sure where the card came from.” Lack of awareness amongst key partners demonstrates the challenge of achieving consistent coordination and communication for future efforts.
- Anecdotal evidence revealed resistance from health providers, primarily community health workers and nurses, who understood the concepts of LAM, yet preferred that women use injectable contraceptives or tubal ligation.

There were several lessons learned from carrying out the study:

- It is imperative to evaluate fidelity in order to ensure that the intervention, in this case the LAM user card, is being implemented as planned.
- Weaknesses in the Guatemalan health system (i.e. outdated reporting forms, frequent staff rotation, unsystematic training procedures, commodity stock-outs, etc.) can interfere with the implementation of a study like this one, regardless of participation and support from providers and department- and central-level MOH officials.
- In order to test and integrate any FP innovation, it is essential to have effective communication between the central-, department- and district- level MOH and providers.

Communication that does not reach all levels may impede success of introducing any new intervention.

- Local district leadership plays a strong role in the quality of services and functioning of a system such as this, which can influence the results of studies.
- While LAM knowledge among providers is already high, tools such as the LAM user card can improve counseling and help users remember method criteria.
- It is difficult and possibly not a priority to test the acceptability and integration of a new material when stock outs exist for current FP materials and even commodities.

Resumen Ejecutivo

Antecedentes

El Método de Lactancia Amenorrea (MELA) es un método moderno y eficaz de planificación familiar (PF) que las mujeres pueden usar durante el posparto y que se basa en el efecto natural que tiene la lactancia sobre la fertilidad. En Guatemala, el MELA forma parte de las Guías Nacionales de Planificación Familiar del Ministerio de Salud Pública y Asistencia Social (MSPAS), así como de las guías de organizaciones de PF como APROFAM y las OGN que prestan servicios de planificación familiar. Pero a pesar de que los proveedores de servicios tienen conocimiento del MELA y de que el método está incluido en las políticas y normas, son pocos los centros de salud que informan a los clientes acerca del MELA, o que lo ofrecen a las mujeres en los controles médicos prenatales, parto y posparto. Como consecuencia de ello, son pocas las mujeres que han oído hablar del MELA o que lo usan.

De acuerdo con la reciente Encuesta Nacional de Salud Materno Infantil (ENSMI) 2008-2009, sólo el 4,6% de las mujeres han usado alguna vez el MELA en Guatemala, lo que es insignificante en comparación con el porcentaje de mujeres que alguna vez usaron un método moderno de planificación familiar (66%). A la vez, la ENSMI indica que la mitad de los niños del grupo de recién nacidos a cinco años de edad son amamantados exclusivamente, lo que podría indicar que una proporción importante de las mujeres recurren exclusivamente a la lactancia pero no practican el MELA. Además, hay algo de confusión entre los proveedores y las usuarias con respecto a los criterios para el MELA; para muchas usuarias y proveedores, la lactancia es equivalente a usar el MELA, lo que produce inexactitud en las cantidades de usuarias de MELA que reportan en exceso los proveedores.

En 2010 y 2011, el Instituto de Salud Reproductiva (IRH) de la Universidad de Georgetown introdujo tarjetas de usuarias del MELA en Mali, India y la República Democrática del Congo como parte del Proyecto de Métodos basados en el conocimiento de la Fertilidad (FAM), financiado por la Agencia de los Estados Unidos para el Desarrollo Internacional. En esos tres países, se utilizaron las tarjetas de usuarias del MELA durante las sesiones de consejería con proveedores y las anécdotas recogidas en ellas indicaron que las tarjetas mejoraban la consejería en el MELA, dado que ayudaban a las usuarias a recordar mejor los tres criterios del método. Además se observaron mejoras en el registro e información de las usuarias del MELA.

De los tres departamentos de Guatemala (Quetzaltenango, Solola y Santa Rosa) donde el IRH presta asistencia técnica para la expansión e integración del MELA, el MSPAS eligió Solola para este estudio. El MELA tiene sentido en el contexto de Solola, donde las comunidades indígenas tienen sólidos sistemas de creencias religiosas, en su mayoría católicas, y una larga tradición de usar la medicina natural así como altos porcentajes de lactancia.

Metodología del estudio

Este estudio de investigación analiza el desarrollo, la introducción y el uso de una tarjeta de usuaria del MELA destinada a: (1) mejorar los informes de usuarias, (2) acrecentar el conocimiento que tengan los proveedores y las usuarias de las condiciones del MELA y (3) facilitar la transición a otros métodos de PF.

Mediante entrevistas con proveedores y actores clave y el análisis de las estadísticas mensuales de los servicios, el estudio procuró establecer si la tarjeta de usuaria del MELA marca una diferencia en los conocimientos del MELA que tengan los proveedores y las usuarias, incluso cuándo cambiar a otro método de planificación familiar, y cómo llevar un registro correcto de las usuarias del MELA en Guatemala. Un estudio cuasi experimental comparó la consejería con la tarjeta de usuaria del MELA (grupo de experimentación) con la consejería que usa solamente el folleto del MELA del MSPAS (grupo de control), que es la norma de atención en Guatemala. Este estudio consistió en tres etapas:

Etapas 1: Capacitación de tres horas de duración en el MELA para los proveedores de los grupos de control y experimentación. El grupo de control recibió capacitación en el uso del folleto del MELA del MSPAS y el grupo experimental recibió la tarjeta de usuaria del MELA para entregar a las usuarias, así como el folleto del MELA del MSPAS.

Etapas 2: Evaluación de línea base realizada tras la introducción de la tarjeta de usuaria del MELA, para medir los conocimientos de los proveedores y uso e información del MELA en los establecimientos de control y experimentación. Se realizaron entrevistas de línea base con los actores para evaluar el valor del MELA, las percepciones con respecto a la aceptabilidad de los proveedores y aspectos relativos a la presentación de informes.

Etapas 3: Evaluación final realizada seis meses después de la evaluación de línea base para comparar las diferencias entre los dos grupos en materia de conocimientos, comprensión, uso e información del MELA. Se realizaron entrevistas finales con los actores para evaluar los cambios en las percepciones evaluadas durante las entrevistas de línea base.

Resultados

Entrevistas con actores clave

En la evaluación de línea base, la mayoría de los actores pensaban que el MELA tenía múltiples beneficios, incluso que promueve una óptima nutrición infantil por medio de la lactancia, no exige ningún producto o artículo básico y le da tiempo a las madres nuevas a elegir otro método de PF después del parto. Sin embargo, algunos mencionaron también las desventajas de ofrecer el MELA, fundamentalmente el hecho de que "exige más compromiso y comunicación [por parte de los proveedores] y que "[las usuarias] tienen más dificultad de usarlo" en comparación con otros

métodos. En la línea base, los actores mencionaron que el MSPAS usa distintos formularios, todavía en circulación en muchos lugares, en los que el MELA aparece agrupado con otros "métodos naturales". Sin embargo, en la evaluación de línea final, los actores manifestaron que los proveedores estaban registrando las usuarias del MELA en los formularios adecuados.

En la línea final, la mayoría de los actores que habían visto la tarjeta de usuarias opinaban que sería ventajoso y práctico en demostrar la forma de usar el MELA y que también serviría para recordar a las usuarias que deben llevar la cuenta de las citas y los tres criterios. Estas opiniones positivas también se observaron en la línea final, cuando los actores describieron la tarjeta como algo útil, de buena calidad y fácil de usar.

Inicialmente, los actores expresaron su preocupación por el alto costo de la impresión de la tarjeta de usuarias y la falta de un sistema para comprar o adquirir las tarjetas. Una solución que se sugirió durante las entrevistas de línea base consistía en incluir las tarjetas en el presupuesto operativo del MSPAS para el año siguiente. Los actores expresaron también sus inquietudes respecto de los prejuicios de los proveedores en contra del MELA. En la línea final, los actores que operan a nivel central y departamental estuvieron a favor de prestar apoyo al uso continuo de la tarjeta, pero los coordinadores de programa expresaron sus dudas de que los encargados de tomar decisiones cumplieran sus promesas. Los actores dijeron que los proveedores tenían ideas erróneas acerca del MELA, como por ejemplo que es lo mismo que la lactancia, menos "moderno" que otros métodos o menos eficaz que otros métodos. Sin embargo, en la línea final, los actores señalaron que las usuarias, no los proveedores, tenían prejuicios que obstaculizaban la integración del MELA en los programas de salud.

Entrevista de los proveedores

En la línea base, los proveedores mencionaron las ventajas y desventajas del MELA. Señalaron que se trataba de un método natural, fácil de usar y eficaz, que ayuda a espaciar los nacimientos y puede representar una opción económica de PF, pero que también presenta dificultades de uso a las mujeres que trabajen fuera de sus hogares, se usa durante un periodo breve y no protege contra enfermedades de transmisión sexual, aunque este aspecto se aplica a la mayoría de los métodos. Los proveedores mencionaron también que algunas mujeres rechazan los métodos naturales y desconfían del MELA porque piensan que hay otros métodos que son más seguros.

Afortunadamente, en la evaluación de línea final, fueron pocos los proveedores, tanto de los establecimientos de control como de experimentación, que dijeron que la lactancia y el MELA son equivalentes. En general, había un alto conocimiento de los tres criterios del MELA, pero era un poco más alto en el establecimiento de control que en el de experimentación.

En ambos tipos de establecimientos, más de tres cuartos de los proveedores manifestaron en la entrevista final que había ofrecido el MELA en los tres meses anteriores. Si bien unos pocos proveedores más ofrecían el MELA en el grupo de control, fueron más los proveedores en el grupo

experimental que ofrecían el MELA durante las consultas prenatales y posparto. Los resultados demostraron también que, al final, el grupo de control usaba siempre el folleto del MELA del MSPAS durante la sesión de consejería, y el grupo experimental seguía usando el folleto del MELA del MSPAS además de la tarjeta de usuaria del MELA. A los proveedores del grupo de control les fue un poco mejor que a los del grupo experimental en la identificación de las tres situaciones en las que las usuarias del MELA deben cambiar a otro método de PF. El conocimiento del grupo experimental de cuándo cambiar a otro método fue mayor en la línea base, pero disminuyó en la línea final.

En ambas entrevistas se preguntó al grupo experimental sobre el uso de la tarjeta de usuaria del MELA y la disponibilidad de la tarjeta. En la línea final, el porcentaje de proveedores que usaban las tarjetas durante la consejería en el MELA había aumentado a 78% y la cantidad de mujeres que recibían las tarjetas del MELA había aumentado también. Sin embargo, la disponibilidad de las tarjetas del MELA sólo había aumentado un poco y ascendía al 65%. En algunos casos, el poco uso de la tarjeta del MELA podría ser resultado de una insuficiente distribución de la tarjeta durante el periodo del estudio, la falta de capacitación en el MELA para los proveedores nuevos o la falta de conocimiento de que el MSPAS autorizaba y recomendaba el uso de las tarjetas en las clínicas.

En cuanto al registro de las usuarias del MELA, en la entrevista de línea base, fueron pocos los proveedores que reconocieron haber registrado alguna vez las usuarias del MELA o anotado a las usuarias en algún registro diario, probablemente a raíz de que estaban usando versiones obsoletas del SIGSA. Sin embargo, en la entrevista final, el porcentaje de proveedores que registraba a la usuaria del MELA ascendía a 70% o más tanto en el grupo de control como el grupo experimental. El registro diario de las usuarias del MELA era alto también en la línea final. Ambos indicadores, no obstante, eran más altos para los proveedores del grupo de control.

Estadísticas del servicio

Se obtuvieron estadísticas de servicio para las áreas de control y experimentación durante un periodo de ocho meses antes de la distribución de las tarjetas del MELA y después de dicha distribución. Los resultados demostraron un leve aumento en las usuarias del MELA al principio del periodo de estudio y luego al final de dicho periodo; pero en los meses intermedios hubo un notable aumento en las usuarias del MELA en el grupo de control. Este aumento en el grupo de control podría deberse a una serie de motivos, incluidos los cambios en el personal del área experimental y la falta de existencias de tarjetas del MELA, razones que fueran mencionadas por los actores como problemas que confrontaron en el área experimental durante el estudio.

Conclusión y Comentarios

Se pueden sacar varias conclusiones generales y específicas que atañen a la futura integración de la tarjeta de usuarias del MELA en Guatemala:

- La mayoría de los actores valoran al MELA como método de PF, pero reconocen que los proveedores tienen prejuicios en contra del MELA, lo que representa un obstáculo importante. Es necesario fortalecer el conocimiento del MELA y mejorar la capacidad de los proveedores de aconsejar y registrar a las usuarias del MELA.
- Los actores consideraron a la tarjeta de usuaria del MELA un método práctico y viable para mejorar el registro del MELA y el conocimiento del método entre las usuarias y los proveedores, pero sigue habiendo preocupaciones con respecto a los costos de reproducción y el compromiso del gobierno con la provisión de las tarjetas.
- Los actores, incluidos un asesor de SSR, y algunos proveedores de servicios de salud indicaron que no estaban familiarizados con la tarjeta de usuaria del MELA, "no tenían órdenes del MSPAS de implementar la tarjeta" y/o "no estaban seguros de dónde venía la tarjeta". La falta de conocimiento entre los aliados clave demuestra la dificultad de lograr una coordinación y comunicación congruente para los esfuerzos futuros.
- Las anécdotas recogidas revelaron que hay resistencia de parte de los proveedores de salud, primordialmente los trabajadores de salud comunitaria y enfermeros, que entienden los conceptos del MELA pero prefieren que las mujeres usen anticonceptivos inyectables o que recurran a la ligadura de trompas.

Se aprendieron varias lecciones con la implementación del estudio:

- Es imperativo evaluar la fidelidad a fin de garantizar que la intervención, en este caso la tarjeta de usuaria del MELA, se implemente según lo planificado.
- Los aspectos débiles del sistema de salud de Guatemala (es decir, formularios obsoletos para presentar información, rotación frecuente en el personal, procedimientos asistemáticos de capacitación, falta de existencias de los productos básicos, etc.) pueden interferir con la implementación de un estudio como éste, independientemente de la participación y el apoyo de los proveedores y funcionarios departamentales y centrales del MSPAS.
- Para probar e integrar cualquier innovación en PF, es fundamental tener una comunicación eficaz entre los niveles central, departamental y distrital del MSPAS y los proveedores. La comunicación que no llega a todos los niveles puede impedir el éxito de la introducción de cualquier intervención nueva.
- Quienes dirigen los distritos locales cumplen una función importante en la calidad de los servicios y el funcionamiento de un sistema como éste, que puede influenciar los resultados de los estudios.
- Si bien el conocimiento del MELA entre los proveedores ya es alto, herramientas tales como la tarjeta de usuaria del MELA pueden mejorar la consejería y ayudar a las usuarias a recordar los criterios del método.
- Es difícil, y posiblemente no sea prioritario, comprobar la aceptabilidad e integración de un material nuevo cuando hay falta de existencias de los actuales materiales de PF y hasta de los productos básicos.

1. Introduction

1.2 Background

The Lactational Amenorrhea Method (LAM) is a modern and effective method of family planning (FP) for postpartum women, based on the natural effect of breastfeeding on fertility. LAM can effectively protect a woman from pregnancy during the first six months after giving birth. In addition, LAM facilitates the transition to other modern methods of FP. It has been proven that at one year postpartum, women who use LAM are more likely to be using another FP method than women who just breastfeed (Bongiovanni A. et al 2005). LAM requires that the user meet the following three criteria:

- The woman's menses have not returned.
- The woman breastfeeds exclusively, day and night, during the first six months after birth.
- The baby is less than six months old.

As soon as the woman no longer meets one of these criteria, she should find another FP method. The World Health Organization has recognized the importance of LAM by including it in their international guidelines. LAM is officially included in the policies and norms in several countries, including Guatemala.

In Guatemala, LAM is included in the National FP Guidelines of the Ministry of Health and Social Assistance (MOH), as well as the guidelines of FP organizations such as APROFAM and NGOs that provide FP services. However, despite providers' familiarity with LAM and its inclusion in policies and norms, few health centers inform clients about LAM or offer it to women in prenatal checkups, birth and postpartum. As a result, few women have heard of and/or use LAM.

According to the recent National Survey of Maternal and Infant Health (ENSMI) 2008-2009, only 4.6% of women have ever used LAM in Guatemala, which pales in comparison to the percentage of women who ever used a modern method of FP (66%). At the same time the ENSMI indicates that half of children aged 0-5 months are exclusively breastfed, which may indicate that a substantial proportion of women are exclusively breastfeeding, yet are not practicing LAM.

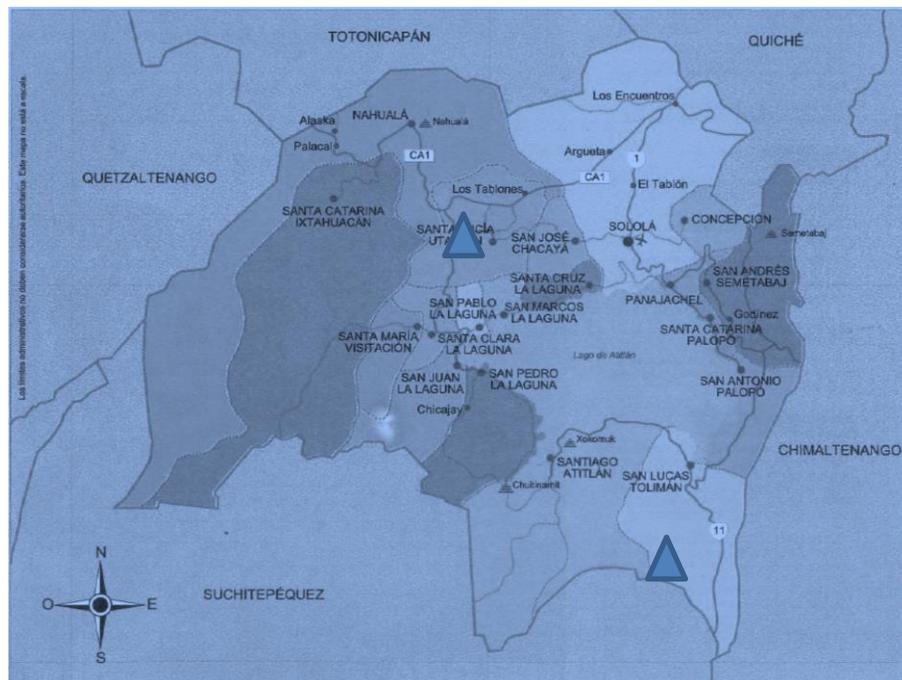
There is also confusion among providers and users alike regarding the criteria for LAM; many users and providers equate exclusive breastfeeding with LAM use, resulting in inaccurate over-reporting of LAM by providers. It is not clear whether the women who decide to use LAM know and meet the three criteria that this method requires to prevent pregnancy. To compound this confusion further, LAM until recently has been included within the broad category of "natural methods" in FP brochures and reporting tools, making it difficult to identify LAM users from the universe of users of other natural methods.

In 2010 and 2011, the Institute for Reproductive Health (IRH) at Georgetown University introduced LAM user cards in Mali, India and Democratic Republic of Congo as part of the Fertility

Awareness-based Methods (FAM) Project, funded by the U.S. Agency for International Development. In all three countries, LAM user cards were used during counseling sessions with providers and anecdotal evidence suggested the cards improved LAM counseling, resulting in better recall of the method's three criteria. Improvements in recording and reporting of LAM users were also noted.

Of the three departments in Guatemala (Quetzaltenango, Solola and Santa Rosa) where IRH is lending technical assistance for scale-up and integration of FAM, the MOH chose Solola for this study. LAM makes sense in the context of Solola, where indigenous communities have strong religious, mostly Catholic, belief systems and a long tradition of using natural medicine, as well as high rates of breastfeeding. Within Solola the MOH chose two municipalities for the study: Santa Lucia Uatlán as the experimental area and San Lucas Toliman as the control area. IRH worked with the MOH to develop a user-friendly LAM user card, for use in LAM counseling by MOH providers.

Figure 1. Map of Solola, Guatemala



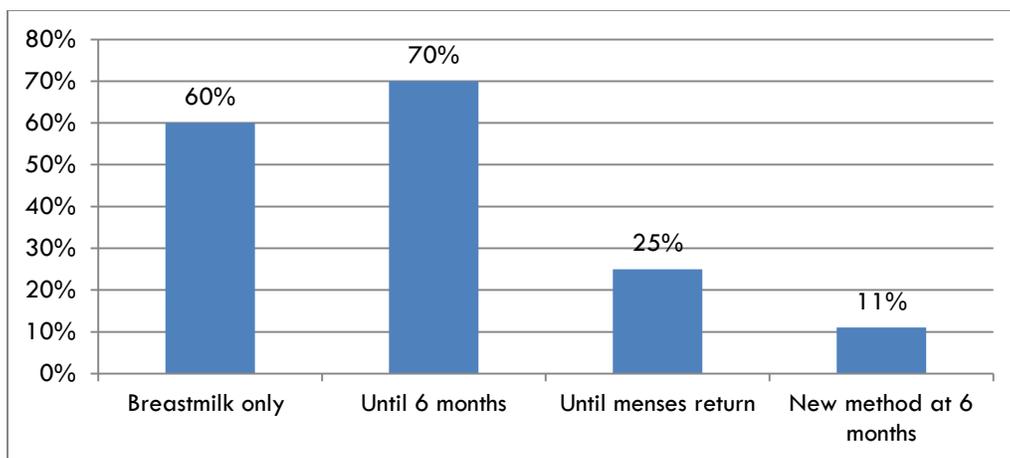
1.3 Formative research

Prior to initiating the study, interviews with LAM users were conducted to assess knowledge of LAM, as well as perceptions of the method in order to inform development of key messages for the user card. Focus groups with FP users were also conducted to better understand opportunities and barriers to LAM integration in services.

Interviews with LAM users on LAM knowledge and perceptions

A total of 36 LAM users, identified through MOH records, were interviewed in local clinics as part of formative research. Most LAM users (69%) received information on LAM during prenatal care, while about half the women heard about LAM during postnatal visits. Of the three criteria to use LAM, most users recalled the exclusive breastfeeding and six-month criteria, while only one-quarter remembered the menses criteria (Figure 2). Women had little to no knowledge of the need to transition to another FP method when any of the LAM criteria were no longer met. These findings confirmed the need to clearly articulate all three LAM criteria in the user card and to emphasize messages about the importance of transition to other methods when LAM is no longer effective.

Figure 2. Users' knowledge of LAM criteria and transition, N=36



Most women cited the advantages of LAM as: economical, accepted by other women, consistent with religious beliefs, good for the health of the baby and the mother, and that the method gives a woman time to transition to another method of FP after childbirth.

About half of the women interviewed knew that a woman who is breastfeeding can become pregnant. Less than half, however, realized that a woman could become pregnant prior to the return of her menses. These results indicate that a substantial proportion of women believe that the return of menses is a marker for the return of their fertility.

Focus groups with FP users on LAM user card integration barriers and opportunities

Eleven FP users, also identified through MOH records, participated in focus groups to discuss potential opportunities and barriers to FP use, including LAM. Participants expressed concern about the involvement of their mothers-in-law in family decision-making. Some mothers-in-law are opposed to FP, expressing the sentiment that there is no reason to control the number of children in the family. At the same time, women often look to their mothers as a source of advice and guidance regarding FP. However, even when mothers may be supportive of FP, traditional understanding of FP methods affect correct use. For this reason, it may be beneficial for

community elders to receive information regarding FP methods as part of the MOH package of sexual and reproductive health (SRH) services.

Both language and cultural factors may affect full adoption of LAM among women in Solola. The term “milk,” for example, is not commonly used to refer to breast milk; “milk” is usually used to refer to cow’s milk or store-bought milk. Instead, communities in Solola refer to breastfeeding as giving breast (“dar chiche”). Use of terminology that is not well understood in the community could result in incorrect use of LAM. Language to describe exclusive breastfeeding should be based on locally accepted terminology and this was also recommended for provider training on LAM. In relation to potential opportunities for LAM integration, women noted increasing openness in the community for smaller families. Some women also mentioned that their husbands would support LAM use. One woman explained how, despite the protestations of her husband’s family, her husband supports FP use because he believes that without FP “the children and the families suffer.”

1.4 LAM user card for Guatemala

At the time of the study, an MOH LAM brochure already existed in Guatemala, one version with images of a Ladino family and the other with images of a Mayan family. The two MOH versions have the same content, including recommendations for and benefits of exclusive breastfeeding, eligibility criteria for LAM, and the criteria that must be met in order to use LAM effectively. The brochure also mentions healthy timing and spacing of pregnancy (HTSP) and has reminders about when to stop using LAM and transition to another FP method.

IRH worked with the Guatemalan MOH to develop a user-friendly LAM User Card (subsequently referred to as the “LAM user card”, “user card” or “card”). The tri-fold LAM user card (Figure 3) includes much of the same information as the MOH LAM brochure, but serves a dual purpose - as an educational tool for providers during counseling and as a user card for clients who want to use the method.

Figure 3. LAM User Card developed by the MOH and IRH



The front of the LAM user card has a line for the user's name and the date of the counseling visit, as well as general information about who can use LAM and when. On the inside of the card, the three LAM criteria are presented using large images and a more detailed explanation of each criteria beneath each image. The back side of the card includes:

- 1) a list of the three LAM criteria with boxes a provider can check off when each criteria is met, including a space to specify the date when the baby will be six months;
- 2) a postpartum appointment section with the user's name, date she gave birth and a reminder about each of her monthly postpartum appointments;
- 3) recommendations for transitioning to another method and images of FP methods appropriate for breastfeeding women; and
- 4) information on the importance of HTSP and advice on continuing breastfeeding after LAM.

It should be noted that unlike the MOH LAM brochure, the LAM user card only exists with images of a Ladino family. A version using images of a Mayan or indigenous family was not developed for this study.

2. Study Methodology

2.1 Study Objectives and Design

This research examines the development, introduction and use of a LAM user card designed to: 1) improve reporting of users, 2) increase provider and user knowledge of LAM criteria and 3) facilitate the transition to other FP methods. Through provider and stakeholder interviews and a review of monthly service statistics, the study sought to determine if the LAM user card improves provider and user knowledge of LAM, including when to transition to another FP method, as well as correct recording of LAM users in Guatemala. A quasi-experimental study compared LAM counseling with the LAM user card (experimental group) to counseling using only the MOH LAM brochure (control group), which is the standard of care in Guatemala.

This study utilized both qualitative and quantitative methods and consisted of three stages:

Stage 1: Three-hour training in LAM for providers in control and experimental facilities. The control group received training using the MOH LAM brochure and the experimental facility received the LAM user card to give to users, as well as the MOH LAM card.

Stage 2: Baseline assessment conducted after introduction of the LAM user card, to gauge provider knowledge and use and reporting of LAM in control and experimental facilities. Baseline interviews with stakeholders were conducted to assess perceived value of LAM, perceptions on provider acceptability and issues around reporting.

Stage 3: Final assessment conducted six months after baseline assessment to compare the differences between the experimental and control groups in knowledge, understanding, use and reporting of LAM. Endline interviews with stakeholders were conducted to assess changes in perceptions evaluated during baseline interviews.

2.2 Intervention

The service providers (auxiliary nurses and doctors) who see women in prenatal visits, labor and delivery, and postpartum checkups in both the experimental and control areas received LAM training. In both cases the LAM training lasted three hours. Providers in the experimental group received a training that explained the three conditions for using LAM, information on when to transition to another FP method, and emphasis on the importance of HTSP. These providers were instructed to give users a LAM user card and an official MOH LAM brochure, according to the current procedure followed during counseling. The control group service providers had the same LAM orientation, but only received a MOH LAM brochure.

Given that providers in both experimental and control groups received refresher training in how to counsel and record LAM users, the study would determine if the LAM user card makes a difference in LAM knowledge among users, as well as correct recording of LAM.

Table 1. Experimental and control group intervention

Experimental Group	Control Group
<p>LAM User Card and MOH LAM brochure</p>  <p>Municipality: Santa Lucia Uatlan (one health center)</p>	<p>MOH LAM brochure</p>  <p>Municipality: San Lucas Toliman (one health center)</p>
<p>Three-hour provider training to review key points of LAM and breastfeeding counseling (with LAM user card and MOH LAM brochure)</p> <ul style="list-style-type: none"> • Three LAM criteria that distinguishes a LAM user from a breastfeeding woman • The transition from LAM to another modern method • Healthy timing and spacing message • Messages on how to use LAM • Messages on the advantages of LAM 	<p>Three-hour provider training to review key points of LAM and breastfeeding counseling (with MOH LAM brochure only)</p> <ul style="list-style-type: none"> • Three LAM criteria that distinguishes a LAM user from a breastfeeding woman • The transition from LAM to another modern method • Healthy timing and spacing message • Messages on how to use LAM • Messages on the advantages of LAM
<p>Providers give LAM user cards to women who choose LAM</p>	
<p>Procedures for recording LAM users in FP clinic register</p>	<p>Procedures for recording LAM users in FP clinic register</p>

2.3 Data Collection

Baseline data collection was conducted after the distribution of the LAM user card in the experimental facility and refresher training for providers. Provider interviews were conducted to assess 1) What messages they convey to clients about HTSP, FP, and LAM 2) How they report LAM users and 3) Attitudes toward the method. Also, stakeholder interviews were conducted with policy makers and program managers in Sololá and at the national level to explore perceptions regarding LAM and the user card.

Table 2. Interviews conducted with providers and stakeholders

	Stakeholders Interviews		Providers Interviews	
	Baseline	Endline	Baseline	Endline
Control Group	--	--	30	27
Experimental group	--	--	44	23
TOTAL	12	10	74	50

Service statistics were collected from the facilities in the control and experimental areas participating in the study in order to provide further information on the number of LAM users reported for the eight months prior to the intervention and eight months during provision of the LAM user card in the experimental group and control group.

2.4 Study limitations

A number of challenges were encountered with the implementation of the intervention, which may have influenced study results.

Intervention fidelity

Due to delays in initial activities, intervention fidelity was not fully maintained. The timeline below lists relevant events pertaining to the intervention's fidelity.

October 2010 – Research protocol developed and process begins for U.S. and local Institutional Review Board (IRB) approval.

March 2011 – Georgetown University IRB approves research study protocol.

April 2011 – LAM training held for providers in control and experimental areas, however, only a small amount of LAM user cards are given to experimental area due to pending approval of revised cards by MOH.

July 2011 – LAM refresher training held for providers in control and experimental areas to strengthen messages, counseling skills and procedures covered in initial training.

September 2011 – Guatemala MOH approves research study protocol.

Baseline data collection begins, including provider interviews.

October 2011 – MOH approves revised LAM user cards for the study¹. LAM user cards are distributed to experimental area providers.

A study fidelity check or supervision visit determines that providers in the experimental area ran out of LAM user cards prior to October 2011.

March 2012 – Endline data collection begins, including provider interviews.

As a result of these events, baseline data for provider interviews does not accurately represent knowledge, use and reporting of LAM users because the user card had become unavailable to some for a portion of the time providers were offering the method in the experimental area.

Incomplete service statistics

Service statistics were not consistently recorded in either the experimental or control group facilities. Inconsistencies stem from the fact that some clinics in both areas, as well as other parts of Guatemala, still use an old version of the FP recording form which consolidates all natural FP methods into one column. Therefore LAM users cannot be distinguished from other natural FP users and as a result, information on number for additional LAM users may be missing from service statistics.

Poor quality training

The research team had the opportunity to observe two LAM refresher trainings for providers, in both the experimental and control areas. While these observations were not systematically recorded, training appeared to be ad-hoc, used limited visual aids and did not follow a clear training plan. Since the training appeared to be of poor quality, providers may not have acquired the necessary knowledge and skills to provide quality LAM counseling and report users correctly.

3. Results

3.1 Stakeholder interviews

The purpose of the stakeholder interviews was to explore the perceived value of LAM, provider bias, and issues regarding recording and reporting LAM users. The interviews assessed stakeholder perceptions of the LAM user card and its utility and feasibility. Stakeholders, including program coordinators, area directors in Solola, and national-level SRH advisors, were interviewed pre and post intervention.

Value of LAM

At baseline most stakeholders felt LAM had multiple benefits. Some of the benefits mentioned were that it:

- encourages optimal infant nutrition through breastfeeding,

¹ The MOH requested changes to the LAM user card, which involved validation of the word “bebe” (baby), as the MOH preferred use of the word “niño/niña” (male child/female child). MOH members felt the word “bebe” was Anglicized Spanish that would not be understood by Guatemala women. The discussions between the MOH and IRH for revisions to the materials and subsequent field-testing resulted in delays in producing and distributing the revised cards to the experimental area.

- prevents pregnancy,
- provides protection at no cost,
- does not require a commodity,
- improves the mother-child relationship, and
- gives the new mother time to choose another FP method after childbirth.

However, some providers also mentioned disadvantages to offering LAM, namely that it “takes more commitment and communication [by providers]” and that “[users] have more difficulty using it” compared to other methods.

Recording and reporting LAM users

Recording and reporting LAM users, as well as users of other FP methods, is challenging in Solola. According to one stakeholder, the biggest problem is quality and timeliness of data, as there may be a time lag between recording and reporting. At baseline stakeholders mentioned that the MOH Health Management Information System (SIGSA in Spanish) includes different and somewhat confusing, duplicative forms. As mentioned previously, in older versions of these forms, still in circulation in many areas, LAM is grouped with all other “natural methods.” The most recent version of the form provides a specific option to report LAM users. Use of outdated versions of recording forms prevents systematic and correct recording and roll-up of data. At endline, however, stakeholders said providers were recording LAM users in the appropriate SIGSA forms. They admitted to previous issues with recording and reporting, especially over-reporting of LAM users, and attributed these errors to lack of orientation for providers on what constitutes a LAM user.

Perceptions of the LAM user card

At baseline, most stakeholders who had seen the card felt it would be beneficial and practical for demonstrating how to use LAM, and would also help users track appointments and the three criteria.

It can be used as a complete family education [tool] to reach the user and facilitate their understanding of LAM. It teaches LAM in a structured way, while keeping track of exactly when she gave birth and to manage her time well [when the three criteria change].

-Stakeholder interview, baseline

These positive opinions were also voiced at endline; stakeholders described the user card as useful, of good quality and easy to use. At endline stakeholders also mentioned receiving positive feedback from providers using the card, including that women were paying greater attention to LAM counseling when they were given the card. Stakeholders liked that appointments could be written down on the card and thought women were more likely to keep the card than a regular informational brochure.

In regards to the content and organization of the card, stakeholders at endline expressed that they thought the card was well-designed and the content was clear. Some suggested the pictures be

adjusted to the Solola context and a Mayan version of the card developed. Stakeholders also thought it would be more appropriate to show the infant on a *zute* a other local cloth, and not over the white cloth used in the card. Stakeholders thought it would be more attractive to use bigger pictures.

Availability and sustainability of the LAM user card

Stakeholders shared varied views on whether the LAM user card could be feasibly implemented within the Solola health system. In the baseline interviews some stakeholders expressed concerns regarding use of the card by providers, namely the high cost of printing the card and the lack of a system to purchase or procure the cards, especially in light of the inability of the district-level MOH to provide print materials for health facilities.

The Ministry [of Health] has never printed materials because materials are always donated by a donor. For the area [Solola] printing materials is expensive and it is difficult for the local MOH to do this, unless it is [supported] by the central level [Ministry of Health].

-Stakeholder interview, baseline

One solution suggested during baseline interviews involved including cards in the MOH operational plan budget for the upcoming year. While funds would need to be identified to reproduce the card, stakeholders felt the use of LAM for postpartum women may actually save costs in comparison to procuring more expensive commodities for other FP methods.

The injections cost 75 quetzales per user. [LAM] could be a cost-benefit in terms of pregnancies avoided and injections saved. Contraceptives, like pills and injectables can be saved and used by women that are not eligible to use LAM. A [cost-benefit] analysis is needed.

-Stakeholder interview, baseline

At endline, feedback from decision makers and coordinators differed in regards to the availability and sustainability of the user card. Solola MOH officials stated that they had department funds to print additional user cards under their IEC budget. At the department-level, stakeholders were in favor of supporting the continued use of the card in the study areas and expanding it to the rest of the department. However, coordinators expressed their doubts that decision-makers would follow through on their promise to print additional cards. Others stated that some health educators had already been told that no more cards were available.

Once the [LAM user] cards run out, well, they run out. Printing is expensive and the Ministry doesn't give materials. We experience constant stock-outs here and even the family planning brochures run out. Every month we request materials and supplies from the health directorate, but they don't prioritize reproduction of materials. The Ministry does have the funds. In the [central MOH] budget they include IEC materials, but they never give us any.

-Stakeholder interview, endline

The problem expressed by the stakeholders above reiterates the issue mentioned previously regarding the difficult of flow of information, and in this case FP supplies, from the central-level

MOH to the department and then district levels. These issues will effect integration of the card in the MOH system.

Barriers to LAM integration and expansion

Although stakeholders responded positively about LAM and its potential to make an impact in FP programs while reinforcing optimal infant feeding messages, they shared concerns regarding provider bias against LAM. Stakeholders thought providers had misperceptions about LAM, such as that it is equivalent to breastfeeding, less “modern” or less effective than other methods.

The truth is that they offer LAM as a method [according to norms and guidelines], but...providers prefer methods that are seen as more modern. The providers see LAM as a bit backwards, and some do not consider it modern, while there are others that resist that [notion]. We must help them see it as modern.

- Stakeholder interview, baseline

At endline, stakeholders pointed to bias from users instead as one of the barriers for LAM integration into health programs. Stakeholders mentioned that health staff consider LAM easily acceptable given almost universal rates of breastfeeding in Guatemala and because it is natural. However, they also noted that users may distrust LAM because it is natural and they perceive hormonal methods as more reliable.

In baseline and endline interviews stakeholders noted both provider and women’s preferences towards offering and using the injectable. Despite the preference for injectables, stakeholders felt LAM was important given breastfeeding rates. In the same vein, they recognized the limited time providers have with each client. Stakeholders recommended advocating with providers on the utility of offering LAM.

At endline, stakeholders also mentioned other barriers to LAM integration and expansion not specific to LAM itself, including high rotation of trained health staff and poor overall recording and reporting of FP users.

3.2 Provider interviews

Providers’ initial perceptions of LAM (Baseline only)

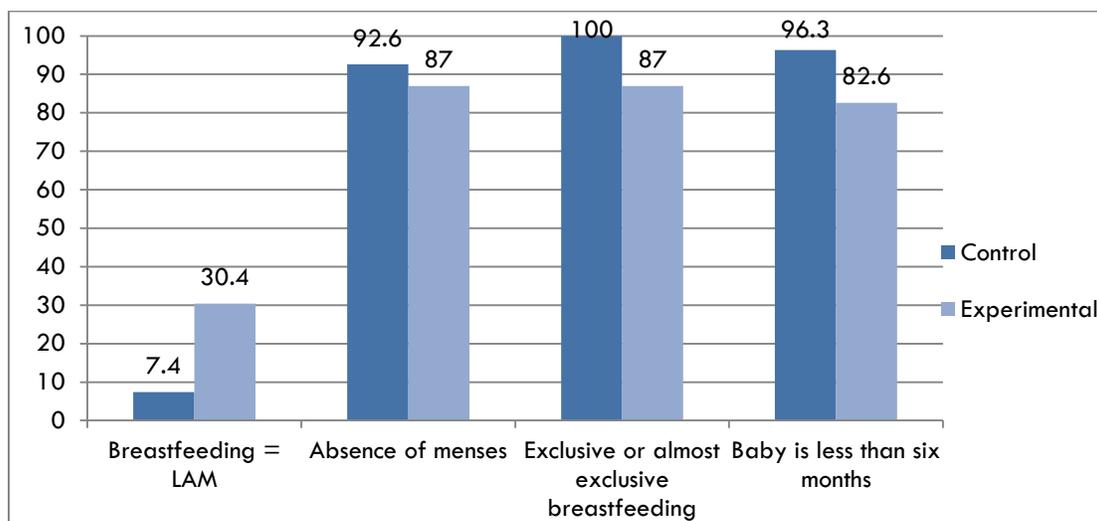
At baseline providers mentioned the advantages of LAM, citing that it is natural, easy to use, effective, and supports birth spacing. They also mentioned that while a woman is using LAM, it is not necessary to purchase infant formula, so the method can save a family money. Providers also cited perceived disadvantages of the method, including the difficulty for women who work outside the home to use the method, the method’s short duration and lack of protection for sexually transmitted diseases – even though this applies to most methods. Interestingly, providers voiced some misperceptions about the efficacy of LAM, such as that some women do not produce sufficient breast milk to use the method or that breasts “do not form well” if a woman uses LAM.

Providers also mentioned certain barriers to LAM use, including that some women reject natural methods and that women distrust LAM because they think other methods are more reliable. It is not clear if this distrust stems from women’s recognition that they do not exclusively breastfeed since providers mentioned foods are often given to young infants in addition to breast milk.

LAM knowledge

Encouragingly, at endline few providers from both the control and experimental facilities reported that breastfeeding and LAM are equivalent (Figure 4). This finding challenges stakeholders’ assumptions that providers believe there is no difference between LAM and breastfeeding. Overall, knowledge of the three LAM criteria high but was slightly higher in the control group than the experimental group (Figure 4).

Figure 4. LAM knowledge at endline (control and experimental group), N=50

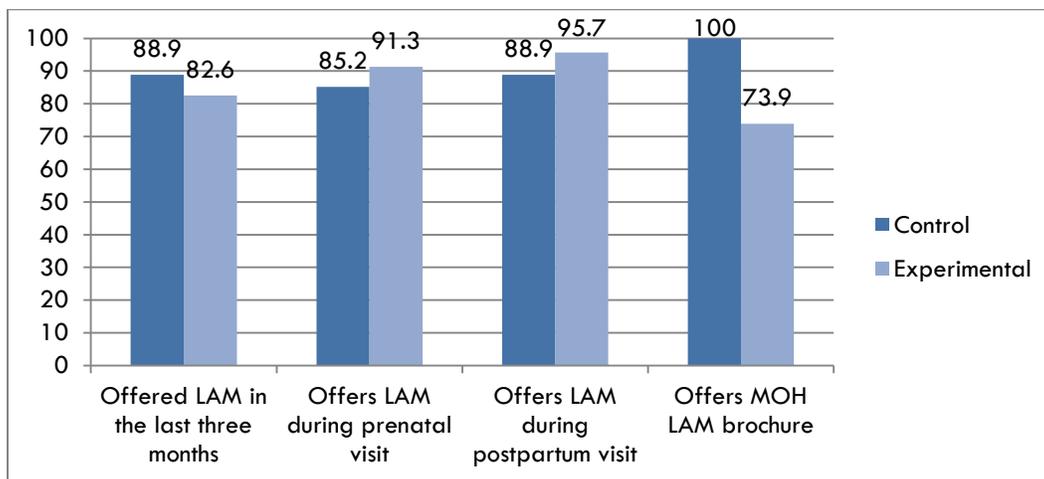


LAM counseling

LAM counseling is normally given by nurses and health educators and is a routine element of antenatal care and postnatal care, health education sessions, and household visits by educators and community health workers. LAM counseling is also provided to women who inquire about the method during other health services.

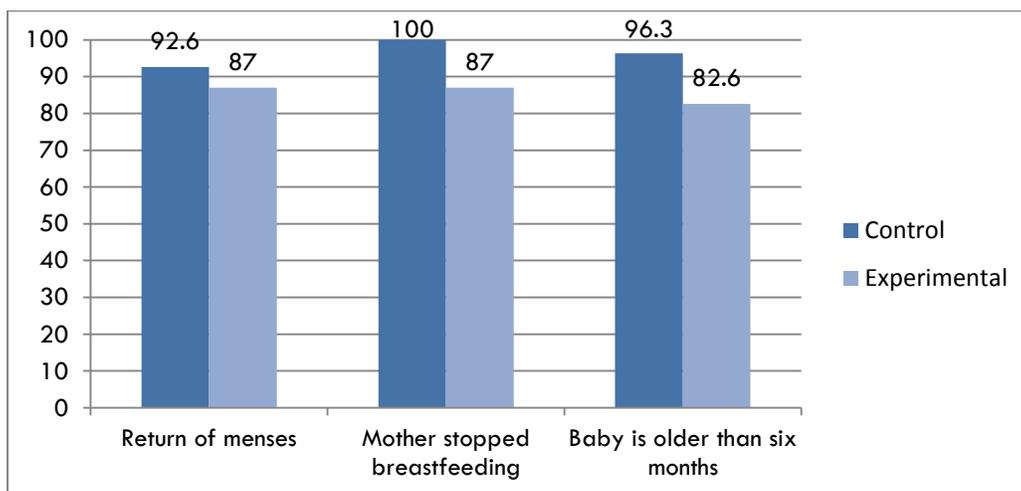
In both the experimental and control facilities, more than three-fourths of providers stated at endline that they had offered LAM in the previous three months (Figure 5). Although slightly more providers mentioned offering LAM in the control group, more providers in the experimental group mentioned offering LAM during prenatal and postpartum visits. Figure 5 also shows that the control group always used of the MOH LAM brochure during counseling by endline, and the experimental group continued using the MOH LAM brochure in addition to the LAM user card.

Figure 5. LAM counseling at endline (control and experimental groups), N=50



Providers in the control group did slightly better than those in the experimental group at correctly identifying all three instances when LAM users should transition to another method of FP (Figure 6). Knowledge of when to transition to another method was higher in the experimental group at baseline, but decreased at endline (Figure 6).

Figure 6. Knowledge of transition criteria at endline (control and experimental group), N=50

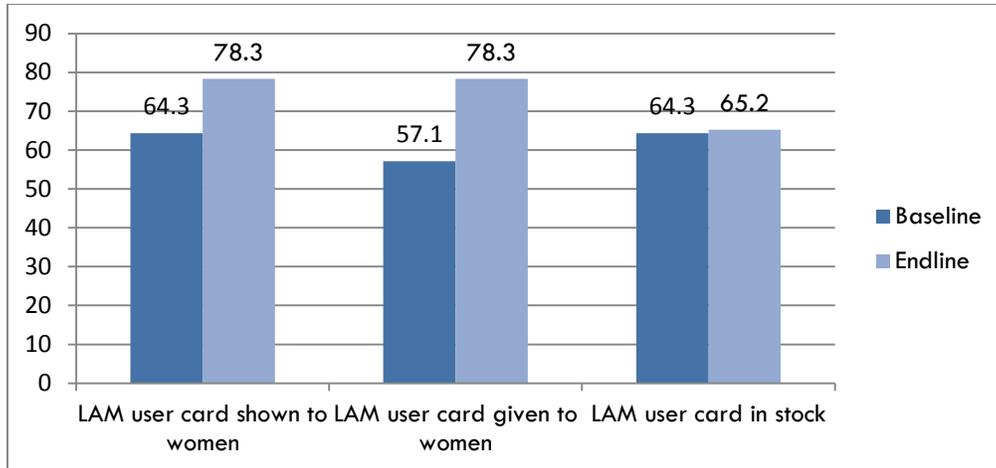


Use of LAM card

At baseline and endline providers in the experimental group were asked about their use of the LAM user card and the availability of the card. At endline, the percentage of providers using cards during LAM counseling had increased to 78% and the amount of women who were given LAM cards also increased. However, the availability of LAM cards only increased slightly to 65% (Figure

7). In some cases, low use of the LAM card may have resulted from inadequate distribution of the card during the study period, lack of LAM training for new providers or lack of awareness that the MOH authorized and endorsed use of cards in clinics.

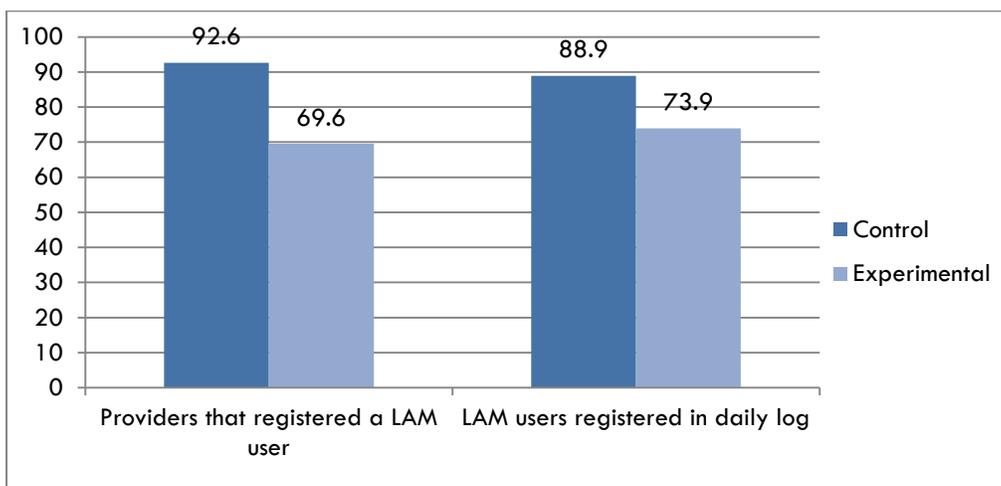
Figure 7. Counseling with the LAM card at baseline and endline (experimental group), N=67



LAM user reporting

LAM users, as well as other FP users are recorded in the SIGSA forms, which are later collected by health centers and combined at the district and later department levels. At baseline few providers noted ever recording LAM users and recording users in a daily register, possibly because they were using old versions of the SIGSA. However, at endline the percentage of providers who registered a LAM user was 70% or higher in both the experimental and control group (Figure 8). Daily registry of LAM users was also high at endline. Both indicators, however, were higher for control providers.

Figure 8. Recording of LAM users at endline (control and experimental group), N=50



3.3 Stakeholders' opinions on study results (Endline only)

At endline, stakeholders were presented key results from provider interviews and asked their opinion on the unexpected results (control group providers with better LAM knowledge and practices than experimental group providers). According to stakeholders, there are several possible explanations:

- The facility in the experimental group suffered significant turnover [in comparison to the control group health centers] during the study period.
- Providers from the experimental group had less schooling than those in the control group.²
- The leadership of the control group's municipality (San Lucas Toliman) is stronger than that of the experimental group (Santa Lucia Utatlan). It is possible that health officials in Santa Lucia Utatlan were not interested in the project.³
- Supervision of health personnel at the district level was lacking, possibly more so in the experimental facility.⁴

3.4 Service statistics

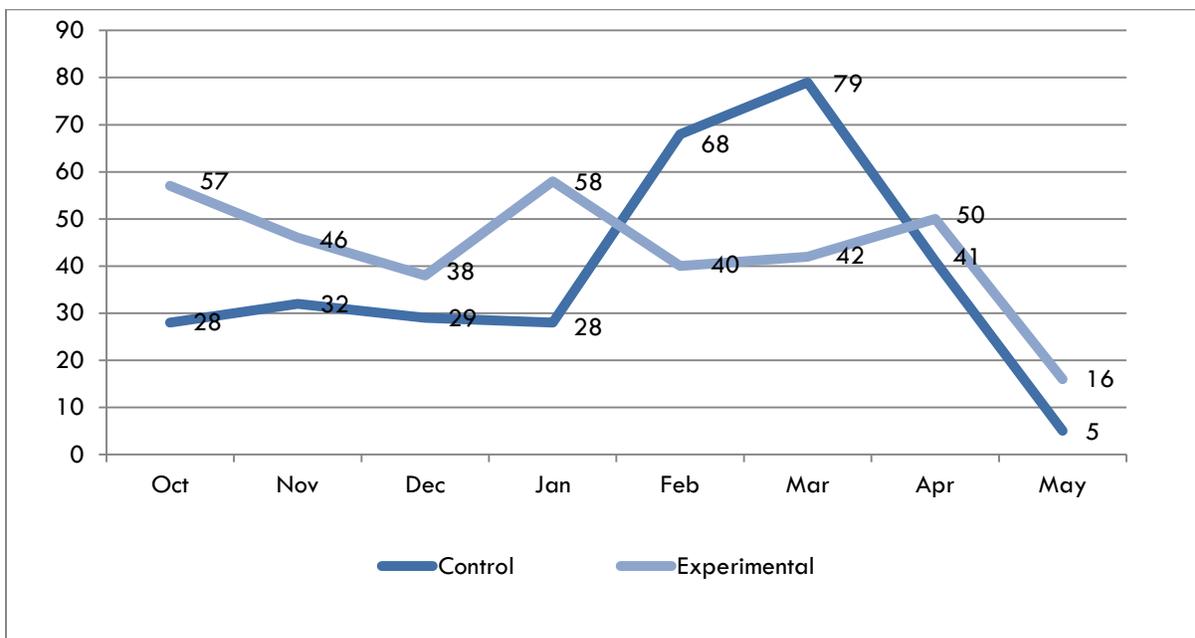
Service statistics were obtained for the control and experimental areas for an eight-month period prior to the distribution of LAM cards and after LAM cards were distributed. Figure 9 shows a comparison of LAM users between the control and experimental area during the period when LAM cards were available. This figure shows a slight increase in LAM users from October to January and then again in April and May, however, in February and March there is a significant increase in LAM users in the control group. A number of reasons could explain this increase in the control group, including staffing changes in the experimental area and stock out of LAM cards, both mentioned by stakeholders as problems faced in the experimental area during the study.

² At baseline there were no major differences between the two groups in relation to LAM knowledge. There is no data to confirm this claim.

³ This may be a plausible explanation, but there is not enough information to confirm this claim. According to accounts from the local study coordinator, the control group site transmitted enthusiasm about LAM while the experimental site was indifferent.

⁴ Overall, the Guatemalan MOH supervision system needs strengthening. In this study, both members of the Solola health directorate and central MOH were invited to join training sessions and supervision visits, but never became involved in these aspects of the study due to time constraints. As a result, all supervision for the study was performed by the local IRH study coordinator.

Figure 9. Number of LAM users according to service statistics at endline (control and experimental group)



4. Conclusion and Discussion

Some general and specific conclusions can be drawn relevant to the future integration of the LAM user card in Guatemala:

- Most stakeholders value LAM as a FP method, but reported that provider bias against LAM was a major barrier. Efforts are needed to strengthen understanding of LAM and improve provider capacity to counsel and register LAM users.
- Stakeholders considered the LAM user card a practical and feasible approach for improving LAM recording and knowledge among users and providers, however, concerns remain regarding reproduction costs and government commitment to providing the cards.
- Stakeholders, including an SRH advisor, and some health providers stated they were not familiar with the LAM user card, “had no mandate from the MOH to implement the card” and/or “were not sure where the card came from.” Lack of awareness amongst key partners demonstrates the challenge of achieving consistent coordination and communication for future efforts.
- Anecdotal evidence revealed resistance from health providers, primarily community health workers and nurses, who understood the concepts of LAM, yet preferred that women use injectable contraceptives or tubal ligation.

4.1 Recommendations

The following suggestions could improve intervention fidelity in pilot studies, as well as the ability of the MOH system to introduce other innovations into their system.

- The purpose of any new FP material should be clearly communicated to providers and coordinators in all health centers where it is being introduced on an on-going basis – once is not enough.
- A local liaison, such as a district- or department-level coordinator, should be designated to facilitate communication and monitor implementation with study teams.
- Outdated recording forms should be replaced with revised forms that utilize MOH statistics.
- Due to the changing environment of health services at the district-level (i.e. high staff turnover) periodic visits to the facilities should be conducted to ensure that providers have been trained and understand how to use new materials and perform new procedures.

4.2 Lessons learned

There were several lessons learned during the course of this study:

- It is imperative to evaluate fidelity in order to ensure that the intervention, in this case the LAM user card, is being implemented as planned.
- Weaknesses in the Guatemalan health system (i.e. outdated reporting forms, frequent staff rotation, unsystematic training procedures, commodity stock-outs, etc.) can interfere with the implementation of a study like this one, regardless of participation and support from providers and department- and central-level MOH officials.
- In order to test and integrate any FP innovation, it is essential to have effective communication between the central-, department- and district- level MOH and providers. Communication that does not reach all levels may impede success of introducing any new intervention.
- Local district leadership plays a strong role in the quality of services and functioning of a system such as this, which can influence the results of studies.
- While LAM knowledge among providers is already high, tools such as the LAM user card can improve counseling and help users remember method criteria.
- It is difficult and possibly not a priority to test the acceptability and integration of a new material when stock outs exist for current FP materials and even commodities.

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