AWARENESS Project
Guatemala Country Report
2002–2007

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Georgetown University
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The *Institute for Reproductive Health*, affiliated with Georgetown University in Washington, D.C., is a leading technical resource and learning center committed to developing and increasing the availability of effective, easy-to-use, natural methods for family planning.

The purpose of the AWARENESS Project was to improve contraceptive choices by expanding natural family planning options and developing new strategies and approaches to increase the reproductive health awareness of individuals and communities in developing countries.

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Acronyms

APROFAM	Guatemalan Family Welfare Association
CA	Cooperating Agency
FAB	Fertility Awareness-based Method
IEC	Information, Education, and Communication
IGGS	Social Security Institute
IRH	Institute for Reproductive Health
KIT	Knowledge Improvement Tool
LQAS	Lot Quality Assurance Sample
MOH	Ministry of Health
NGO	Non-governmental Organization
SDM	Standard Days Method®
SIGSA	National Logistics System
TDM	Two Day Method®
URC	University Research Corporation
USAID	United States Agency for International Development

The AWARENESS Project

Expanding Family Planning Choices Worldwide

Country Program Summary
Guatemala

November 2007

Country Context

With a population of 12 million, Guatemala is the largest country in Central America. Contraceptive prevalence in 2002 was relatively low, at 43% for women aged 15–49, and was even lower among rural (under 35%) and indigenous women (24%). In 2002, the Ministry of Health (MOH) and the Social Security Institute (IGGS) requested assistance from the AWARENESS Project to expand contraceptive choice through the integration of fertility awareness-based methods (FAM) into the method mix. The program functioned in USAID priority zones including the largely indigenous departments of the Altiplano (Quetzaltenango, Solola, and Huehuetenango), Santa Rosa, Chimaltenango, and Alta Verapaz. It focused primarily on building evidence for the future scale-up of the Standard Days Method® (SDM), while also assessing the effectiveness and feasibility of the TwoDay Method ® (TDM).

Approach

- Test and document strategies for the provision of quality, sustainable SDM services in public- and private-sector reproductive health programs.
- Test the efficacy of the TDM and the feasibility of providing it in routine service delivery.

Activities

IRH used a diversified strategy to build the evidence base for FAM and subsequently establish the necessary support and conditions for scale up. Activities included:

1. Conducting research in partnership with USAID-supported NGOs working in priority health geographic areas characterized by low contraceptive prevalence.
2. Supporting resource nongovernmental organizations (NGOs) for ongoing training, technical and material support to NGO networks and community- and faith-based organizations.
3. In partnership with a USAID cooperating agency, Calidad en Salud (University Research Corporation), developing information, education, and education (IEC) materials adopted by the national family planning program.
4. Providing training, materials, and technical support to IGGS and the MOH.

Key Results

With approximately 200 trainers and 2000 trained SDM providers, Guatemala has substantial capacity for offering SDM services. In the last three years, more than 13,000 women began using the SDM, most of whom previously had not used family planning. The SDM also is supported in norms and gradually is being included in management information and logistics systems, pre- and in-service training, and communication strategies.

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Research

Two Day Method® Efficacy Trial:
Guatemala was a site for the multicountry TDM efficacy trial, in which the method proved to be over 95% effective. Community-based providers were capable of offering high-quality counseling in the method, and most couples were able to use it correctly.

Long-Term Follow-Up Study of Women Completing TDM Efficacy Trial:
Total pregnancy rates were 7.8 and 5.1 per 100 woman-years of typical method use in years two and three, respectively. Of women entering the follow-up study, 61% completed 24 months of additional method use (thereby completing three years of use).

Comparison of tools for teaching and using the SDM:
Addressing the concern of the Guatemalan MOH that CycleBeads® might be too costly, a paper image of CycleBeads was developed. A study to compare the acceptability and cost of CycleBeads and the paper image was conducted over an 18-month period (July 2005 to December 2006) and involved 600 SDM acceptors randomly offered either tool by approximately 90 trained nurses and nurse auxiliaries. Researchers also assessed the quality of service provision. Preliminary study results indicate that providers have a preference for CycleBeads, citing them as easier to use and teach, more attractive, and more effective in engaging the woman's partner. Clients use both tools equally well but prefer CycleBeads. The three study regions subsequently allocated funding for the purchase of CycleBeads.

Knowledge Improvement Tool (KIT):
Supervision is an essential but potentially costly component of quality SDM services. A study of KIT—a supervision tool to reinforce provider knowledge of the SDM—aimed to: 1) compare its effectiveness to other methodologies for improving provider knowledge; and 2) compare the cost-benefit of KIT to these other methodologies. The study compared KIT used on a one-on-one or group basis with a two-hour SDM refresher training and a control group. Preliminary results suggest that the most cost-effective approach to reinforce provider knowledge is a group KIT activity.

> *In the community, there's time to understand…In the health centers…people treat you badly because you can't afford to go to a doctor.*
>
> ***SDM users voicing preference for community-based services***

SDM Self-Study Module:
Training large numbers of geographically dispersed providers can be costly and time-consuming. IRH developed a self-study module and tested its potential for building providers' capacity to counsel clients in the SDM. This study confirmed the acceptability and effectiveness of a self-directed learning module with 120 auxiliary nurses.

SDM Integration

- The SDM was included in national contraceptive norms in 2002. IGSS included the SDM in its norms in 2003.
- Resource NGOs trained dozens of small NGOs in the SDM, including approximately 900 providers in 38 organizations and 39 communities.
- AMIGAS and APROVIME continue as national resource NGOs, addressing requests for training and new materials, and marketing SDM training packages to other NGOs. Both organizations have stocks of training materials and CycleBeads.
- The SDM is integrated in MOH and IGGS services. MOH national logistics systems incorporate CycleBeads, with stock already available to departments proactively requesting it. MOH reporting systems now include the SDM.
- IGGS completed training of different levels of providers at 38 IGGS hospitals and clinics and

integrated the SDM into logistics, reporting, and supervision systems. Training participants included 192 community providers and 209 clinic-based providers.

- Several schools of nursing and auxiliary nursing are in the process of integrating the SDM into their pre-service curricula.
- *Calidad en Salud* integrated the SDM into national IEC materials and family planning training programs.

Lessons to Guide Future Programming

- There is significant potential for SDM scale-up through both public- and NGO-sector organizations.
- Community-based services are an effective strategy to reach underserved populations, particularly in low CPR areas, with both SDM and TDM.
- Sustainable capacity in SDM counseling can be achieved through NGO networks, in-service and pre-service training, and a self-study approach. Similar approaches should be tested for expanding access to the TDM.
- CycleBeads need to be fully integrated into MOH procurement and distribution systems.

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[1] 2002. *Encuesta Nacional de Salud Materno Infantil (DHS)*, p.83.

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I. Introduction

Source: CIA World Factbook 2008

With a population of 12 million, Guatemala is the largest country in Central America. Despite more than thirty years of family planning programming, contraceptive prevalence remains relatively low, at 43% of women aged 15–49 and even lower among rural (under 35%) and indigenous women (24%).[1] Of women using any family planning method, nearly 9% practice some form of natural family planning, although no more than 40% of periodic abstinence users could identify the midpoint of the cycle as the time they face the greatest risk for pregnancy.

Given these circumstances, there is a high level of interest in improving access to family planning in Guatemala, one strategy being to expand contraceptive choice through the integration of fertility awareness-based (FAB) methods into the program. The Standard Days Method® (SDM) is an important part of this strategy. At the request of the Ministry of Health (MOH) and the Social Security Institute (IGGS), the Georgetown University Institute for Reproductive Health (IRH) provided technical assistance over the last five years to scale up method access on a national level.

IRH began working in Guatemala in 2002, when it initiated activities related to SDM introduction. Because of previous work done by the Population Council, a variation of the SDM was already included to a limited degree in the method mix in Guatemala. However, when the results of an SDM efficacy study demonstrated a greater effectiveness with a slightly lengthened fertile window, both the MOH and the IGGS revised the national contraceptive norms. As such, the SDM was introduced in 2002, with IRH, other cooperating agencies (CAs), the MOH, and several nongovernmental organizations (NGOs) collaborating to integrate the method into public- and private-sector family planning programs.

In the private sector, IRH partnered with the NGOs AMIGAS, APROVIME, Genesis, and Belejeb Batz for scaling up and research activities. Both AMIGAS and APROVIME continue to serve as national resource NGOs for the SDM, responding to requests for training, assisting in the development of new materials, and supporting efforts to test and market SDM training packages to other NGOs. Both organizations have stocks of training materials and CycleBeads®. IRH also collaborated with the USAID cooperating agency *Calidad en Salud* (implemented by University Research Corporation [URC]), which provided technical assistance to the MOH on family planning, including the SDM. In the public sector, IRH provided support and training through a consultant to IGGS, and conducted research on SDM service delivery with the MOH.

The program implemented research and scaling-up efforts in USAID priority geographic areas, including the largely indigenous departments of the Altiplano (Quetzaltenango, Sololá, and Huehuetenango) as well as Santa Rosa, Chimaltenango, and Alta Verapaz. MOH and IGGS services in several departments also offer the SDM, although the degree of integration varies from clinic to clinic. The training curricula of several MOH nursing programs have incorporated

[1] 2002. *Encuesta Nacional de Salud Materno Infantil (DHS)*. Guatemala :Instituto de Estadística de Guatemala (INE) p.83.

the SDM. Efforts continue to fully integrate CycleBeads into MOH logistics systems, with an adequate stock already available to those departments that are sufficiently proactive to request supplies. Through 2006, an estimated 7,500 women were using the SDM in Guatemala, in both the public and private sectors.

IRH completed an efficacy trial of the TwoDay Method® (TDM) in 2003, followed by a 24-month follow-up study of women who had participated for one year in the efficacy trial. This study was completed in October 2005 in Totonicapan, Guatemala, and in Iquitos and Piura, Peru.

II. Goal, Objectives and Strategy

Goal:
Initially, the project goal was to build an evidence base on fertility awareness-based methods to guide their introduction worldwide as well as in Guatemala. As it became apparent that there was significant interest in these methods in Guatemala, focus shifted to laying the groundwork for scaling up the SDM and conducting further studies on the TDM. To increase access to these methods, specifically the SDM, IRH continues to develop an evidence base to support their integration into programs; develop tools to facilitate their adoption by programs; and provide training, IEC materials, and technical support to ensure demand, availability, and high-quality services.

Objectives:
Through its work in Guatemala, IRH sought to:

- Support efforts to integrate the SDM into public- and private-sector programs in order to expand family planning options and ensure high-quality services.
- Document and test strategies for the provision of high-quality, sustainable SDM services.
- Develop and test an SDM distance-learning module, which may provide a more cost-effective means of training providers.
- Evaluate the cost-effectiveness in maintaining provider competence and quality of care of a supervision tool—the Knowledge Improvement Tool (KIT)—as compared to refresher training.
- Coordinate with nurse/nurse auxiliary programs to include the SDM in their family planning curricula.
- Conduct operations research on the TDM on issues such as correct use, continuation, and use of other methods after discontinuation.

Strategy:
IRH and its public and private-sector partners pursued a diversified strategy to build the evidence base for fertility awareness-based methods and subsequently establish the necessary support and conditions for SDM integration. This included:

- Development of information, education, and communication (IEC) materials subsequently adopted by the national family planning program, in partnership with *Calidad en Salud*.
- Research conducted in partnership with USAID-supported NGOs working in priority areas characterized by low levels of contraceptive prevalence and a strong inclination towards fertility awareness-based methods.

- Development of tools and strategies that could contribute to sustainable services. The program, in partnership with *Calidad en Salud*, developed a paper alternative to CycleBeads and tested it in MOH service delivery sites. It also validated a self-study module for training SDM providers with public-sector providers in multiple sites and tested supervision tools with local NGOs.
- Provision of training, materials, and technical support to IGGS, a large-scale public-sector health care provider, for SDM integration.

III. Activities and Accomplishments

To achieve program goals and objectives, IRH worked with the private and public sectors, NGOs, international organizations, and faith-based organizations in USAID priority departments, including Quetzaltenango, Chimaltenango, Santa Rosa, Sololá, Totonicopan, and San Marcos.

Table 1: Activities, Responsibilities, and Key Achievements

Collaborating Organizations	Activities Undertaken	Partner's Role	IRH's role	Accomplishments
Ministry of Health (MOH)	• Provider training • Research: o SDM provider tools (Paper vs. Plastic) o Self-study methodology	• Provide technical input and support • Contribute staff and facilities for training, meetings, and service delivery	• Develop training methodologies, research protocols • Perform data collection and analysis • Provide technical assistance	• Staff trained in numerous sites throughout the country • Provider tools (CycleBeads and paper carnet) comparatively evaluated • Distance learning methodology developed and validated
Social Security Institute (IGGS)	• Provider training • Validation of self-study methodology	• Provide counterpart support, staff time, facilities • Actively offer SDM in select sites	• Provide training and ongoing technical assistance	• Method integrated into IGGS services • Self-study methodology validated
Calidad en Salud	• Development of IEC materials • Integration of SDM into MOH training programs	• Develop IEC materials for national family planning program • Conduct training and technical updates for MOH providers	• Review materials • Provide training content.	• SDM integrated into training activities of MOH and IGGS • SDM included in MOH family planning materials
Belejeb Batz	• Training for NGOs • Development and testing of SDM training "packages" • Provision of SDM services through clinics and community pharmacies	• Provide training and follow-up support to NGOs • Provide services • Develop SDM training packages to sell to interested organizations	• Provide technical assistance, training, monitoring, and materials review	• Several NGO staff trained in SDM provision, including USAID-supported *Proredes* NGO network • Technical assistance package developedSDM integrated into services

Collaborating Organizations	Activities Undertaken	Partner's Role	IRH's role	Accomplishments
AMIGAS	• Training/resource NGO for organizations interested in integrating SDM • Testing of knowledge improvement tool, comparing efficacy to other refresher training strategies	• Provide trainings • Implement research agenda and collected data	• Provide technical assistance • Develop study protocol and analyze results	• Dozens of small NGOs trained in SDM, many of which are actively offering services • KIT compared to refresher training
APROVIME	• Research related to the TDM and postpartum guidelines • Operations research testing different tools for SDM provision (paper image versus necklace)	• Implement research	• Provide study protocols, technical assistance and supervision, and analysis	• Information regarding provision of TDM and SDM gathered • TDM successfully tested • Strengthened links to MOH and participating NGOs
Genesis	• SDM introduction into the services of the MOH and select NGOs in two municipalities of Chimaltenango Department	• Train providers • Conduct follow up and collect service statistics • Conduct lot quality assurance sample (LQAS) to gauge impact of intervention in terms of use, knowledge, and acceptability	• Provide training and support in developing IEC materials and technical assistance on LQAS	• SDM available in Chimaltenango Department • Experience using LQAS methodology as well as information regarding the effectiveness of intervention
Proredes	• Provision of SDM training and follow-up support for network of 12 USAID-funded NGOs	• Provide staff and venue • Organizations offer SDM services and participate in follow-up activities, including testing of KIT as a refresher tool	• Provide support for training • Develop strategy for follow-up support, including study protocol for testing KIT	• Several NGOs trained and actively offering the SDM in the Guatemala highlands • Information related to the efficacy of KIT as a supervision tool available
Catholic Relief Services	• Training for clinic and community-based health providers on the SDM	• Cover training costs • Purchase CycleBeads	• Provide training and follow-up support	• SDM available in the dept of Alta Verapaz through "extensión de cobertura" program

Collaborating Organizations	Activities Undertaken	Partner's Role	IRH's role	Accomplishments
Guatemalan Family Welfare Association (APROFAM)	• Four contraceptive technology updates given to family planning providers	• Finance two hour training on the SDM • Purchase CycleBeads	• Provide training and follow-up support	• Two-hour training/orientation on SDM for APROFAM, the largest private-sector provider of family planning • Services available in select clinics

A. Research

As described below, IRH conducted a number of studies in Guatemala over the course of the project. Researchers were in the process of finishing data analysis and documenting results on several of these studies at the time this country report was written. Once final study reports are available, they can be obtained on the IRH Web site, irh.org.

i. Efficacy and continued use of the TDM

To test the efficacy of the TDM, which is based on monitoring cervical secretions to identify the fertile days of a woman's menstrual cycle, IRH conducted an international clinical trial in five sites in three countries. Efficacy was over 95%.

Following the trial, which showed that the method was highly effective, IRH implemented a 24-month follow-up study of women who completed the efficacy study. This study's aim was to learn more about TDM use including continuation, use of the method to achieve and prevent pregnancy, and use of other family planning methods after discontinuing. Researchers implemented this long-term follow-up study in three of the five sites where the efficacy trial was conducted: Iquitos and Piura in Peru and Totonicapan in Guatemala. The study found that method effectiveness was very high and total pregnancy rates were 7.8 and 5.1 pregnancies per 100 women/years of typical method use in years two and three, respectively. Method continuation was also high. Of women entering the follow-up study after participating in the efficacy trial, 61% completed 24 months of additional method use (thereby completing three years of method use). For complete research results, refer to the study's final report available at

ii. Development and test of guidelines for postpartum transition to SDM

Because there is an unmet need for family planning in the first year postpartum, IRH developed and tested guidelines for postpartum women to transition from lactational amenorrhea to SDM. The guidelines cover three distinct phases and users follow different instructions in each phase to identify when they can have unprotected intercourse without becoming pregnant.

The pilot study, conducted in Guatemala and Peru, followed 212 participants on a monthly basis as they moved through the different phases of the guidelines. Researchers collected data on pregnancy status, compliance with method instruction, ease of use, and acceptability. A final study report is forthcoming.

iii. Comparative study of CycleBeads and paper image

IRH collaborated with APROVIME and the MOH on a comparative test of CycleBeads and a paper image for the provision of the SDM. The study took place between July 2005 and December 2006 and involved 600 SDM users. The MOH—which is committed to offering the SDM nationally—requested the study to address its concerns regarding sustainability of SDM services due to the cost of CycleBeads. This study provided useful information to guide policy in Guatemala and around the world for purchasing CycleBeads or using the paper image.

A potential SDM client listens as a MOH provider explains the concept of cycle length.

Before introducing the paper image on a national level, the MOH and IRH agreed to compare the tools in a service delivery setting. *Calidad en Salud* had previously validated the paper image, with technical assistance and funding from IRH. However, regular health services had never offered the paper image. *Calidad en Salud* worked with IRH to develop a provider training manual as well as IEC materials. For the study, IRH/APROVIME and *Calidad* periodically met to assess progress and to discuss service-delivery strategies.

To plan for the study, in April 2005, IRH met with representatives from the reproductive health unit of the MOH and three health areas selected for the intervention. These included Solola, Quetzaltenango, and Santa Rosa and involved 54 health centers and posts in 14 districts. Subsequently, the program trained approximately 90 nurses and nurse auxiliaries to offer the SDM using the two modalities. Service delivery was underway by October 2005.

Providers followed the MOH family planning counseling protocol and invited those opting for the SDM to participate in the study. Those who agreed were randomly assigned to a tool and then followed for up to six months by field interviewers in order to collect information on correct use, satisfaction, and continuation. Field staff also interviewed providers to evaluate competence with each of the tools.

Researchers completed data collection in the spring of 2007 and, at the time of this report, were analyzing results. The final report will be available at www.irh.org.

iv. Knowledge Improvement Tool (KIT)

In most settings, after receiving a one- to two-day initial training to offer the SDM, trained providers require refresher trainings and ongoing support to ensure high-quality services. This can be both costly and time-consuming. To address this concern, IRH developed the KIT as a supervision tool to reinforce provider knowledge of the SDM. The KIT guides family planning supervisors to ask the provider a list of questions, reinforce correct answers, and address any knowledge gaps.

IRH designed and implemented a study to: 1) compare the effectiveness of KIT to other methods of improving SDM provider knowledge, and 2) compare the cost-benefit of using KIT to other methods of improving SDM provider knowledge. This comparative study involved gathering data related to SDM knowledge among providers who received refresher training/support through the application of three different methodologies: KIT applied on a one-on-one basis, KIT applied in a group setting, and a two-hour SDM refresher training. A fourth group—the control—received no refresher training. Providers from ten NGOs belonging to the USAID-supported *Proredes* network participated. One trainer had previously conducted an one-day training for all participants within a two-month time span in mid 2004.

Staff completed data collection in the summer of 2007 and drafted a final report. Preliminary results suggest that the most cost-effective approach to refresher training is a group KIT activity. A separate final report on the study is available at www.irh.org.

v. SDM self-study module

Operations research has demonstrated that health care providers of different backgrounds can effectively offer the SDM in various settings. Despite the potential for wide accessibility, the dearth of resources available to train providers, particularly in rural areas, has impeded the effective integration of the method into services in many programs. To address this need, IRH developed an entirely self-directed learning module for low-level family planning providers. This module, which includes written assignments and practicums, allows providers to gain the counseling skills and master the information necessary to offer the SDM. The module includes evaluation tools (a pretest, homework assignments, and a final exam) that a facilitator reviews to determine whether providers' skills are adequate to offer the method. IRH tested this curriculum with 120 nurse auxiliaries working for public and private family planning service providers in Guatemala. The evaluation demonstrated the module's effectiveness in imparting the necessary skills for providers—at least for providers at the nurse auxiliary level and above—to offer the SDM competently and correctly to clients. The effectiveness of this methodology has important implications for integrating new initiatives and interventions into health programs which otherwise might have to forgo such opportunities. A complete report on the self-study module and its validation is available at www.irh.org.

B. Building awareness of and support for SDM

IRH launched the SDM in late 2002 in Guatemala City with representatives of the MOH, USAID, IGGS, and key NGOs and CAs in attendance. This event was held shortly after the SDM was included in the national contraceptive norms. The launch generated favorable publicity, including press coverage and assurance of support from a number of the organizations present. Shortly thereafter, *Calidad en Salud* included SDM in a new round of IEC materials developed for the MOH. *Calidad* also incorporated SDM in its family planning training program for MOH and IGGS providers. While these developments were important, it was difficult to maintain enthusiasm for the integration of the method without a dedicated advocate within the MOH or IGGS.

IRH therefore cultivated relationships with NGOs and individuals within the public sector. The IGGS strongly supported the method, with uptake progressing well during the 18 months

following the launch. However, IGGS was forced to eliminate family planning services for almost a year due to political and financial obstacles. Efforts at the MOH were less promising, although the paper carnet study noted earlier created awareness of the method's acceptability to the population. As such, particularly in the three geographic areas where the study was implemented, interest increased in integrating the method into services and each earmarked funds for the purchase of CycleBeads.

A large-scale IEC campaign conspicuously lacked in efforts to increase awareness and support for the SDM. Although the method was included in the MOH family planning IEC materials, this in itself has not created sufficient awareness of the method. Limited funding, the absence of a cohesive scale-up strategy in Guatemala (which has been more focused on research than scale-up), and no local dedicated presence to advocate for the method have hindered integration. Going forward—to achieve a true national presence and sustainable services—these issues will need to be addressed.

C. Developing the capacity of local organizations

To develop capacity in the public and private sectors, IRH primarily relied on its partnership with a local "resource" NGO, which assumed responsibility for training and supporting organizations interested in offering the SDM. This was an effective although limited strategy, given the size and geographic reach of the NGO, Belejeb Batz. IRH chose to develop the capacity of this small NGO working with women's micro-credit groups, as it was starting to integrate health topics into its work with women. The partnership also presented opportunities to test a community-based social marketing effort and use a SDM technical assistance package Belejeb Batz developed to provide assistance to other small NGOs in the region. IRH also worked with a spin-off NGO, AMIGAS, managed by Belejeb Batz staff. Through AMIGAS, IRH succeeded in training nearly 400 private-sector providers at 12 NGOs.

In the public sector, the approach with the MOH was more complicated given the challenges of coordinating trainings. Furthermore, providing the necessary follow-up after training proved difficult due to the nature of working with a large, bureaucratic entity. The public-sector trainings were part of a broader *Calidad en Salud* effort to train family planning providers on multiple methods in several departments. Unfortunately, there was inadequate follow-up support, and trainees did not receive the necessary commodities and tools to offer SDM services. Other efforts to engage the public sector included trainings provided by Genesis, an NGO in Chimaltenango, and work done as part of the study to compare service provision tools for the SDM. While these efforts functioned to generate interest within the MOH for the method and resulted in several hundred trained providers, this is not a long-term, sustainable strategy for scale up. Sustainability will only be achieved through the integration of SDM training in the curricula of nurses and nurse auxiliaries, as they are the primary family planning service providers at MOH facilities.

The other major public provider is IGGS, which demonstrated a greater commitment to the method by assigning two staff members to spearhead integration of the SDM into logistics and reporting systems as well as supervision efforts through the application of the KIT. IGGS's family planning IEC materials also featured the SDM. This success was somewhat muted by the

fact that IGGS's family planning program had a significant setback due to financial and political problems. Consequently, IGGS services have relatively few family planning users. In addition, while much has been done to promote sustainability, the SDM is not yet officially included in the pre-service curricula of IGGS providers, and IGGS does not budget for the purchase of CycleBeads (although a substantial number were donated and the method is available in most IGSS clinics).

i. NGO Sector

a. Belejeb Batz

As part of efforts to incorporate the SDM into the NGO sector, IRH partnered with Belejeb Batz, an NGO based in Quetzaltenango that focuses on serving indigenous men and women. Belejeb Batz has integrated the SDM into its own programs and serves as an in-country resource center for the SDM, providing training, technical assistance, and materials support. IRH funding for Belejeb Batz ended in March 2005, but the NGO continues to offer the SDM and respond to NGO requests for support and training.

IRH supported Belejeb Batz to focus on: 1) IEC activities to generate awareness of this new method of family planning, 2) technical assistance to NGOs offering or interested in offering the SDM, 3) training for providers and trainers, and 4) family planning service delivery, including the SDM.

Belejeb Batz implemented activities in 21 indigenous communities in the Guatemalan highlands. Belejeb Batz clinics and volunteers offered the SDM as well as other family planning methods. At the end of the project, the NGO reported 700 active family planning users, of whom 32% were SDM users. Of these SDM users, over 80% reported that they had not previously used family planning. Belejeb Batz also provided support to other organizations interested in integrating the SDM. This included training 356 providers from 11 organizations in the SDM and providing materials (job aids, counseling manuals, supervision guide) for them and users.

b. Genesis

IRH partnered with the NGO Genesis to introduce the SDM into the services of the MOH and select NGOs working in two municipalities of Chimaltenango department. The NGO trained MOH staff at the health units serving these municipalities, as well as the community extension volunteers associated with these units, including nurse midwives and community health promoters. In addition, Genesis trained key personnel from two NGOs working in these areas, Chuwi Tinamit and Kajih Jel, which subsequently integrated the SDM into their health programs.

In the project's specific geographic target area, Genesis trained 119 MOH and 24 NGO personnel in one hospital and 15 health centers in 16 communities. Before Genesis began training and IEC activities, there were no SDM users in either municipality. Through June of 2004, these trained providers reported 126 SDM users (although, given the unreliability of MOH reporting systems, this is likely a significant undercounting of actual users). While no specific

data are available on the percentage of total family planning users that SDM users represent, results from the LQAS endline survey suggest that approximately 40% of all family planning users in Patzicia and Chimaltenango were SDM users. (See Table 2.)

A comparison of the baseline and endline surveys shows significant changes in a number of indicators. Highlighted results include:

- An increase of approximately 11% in Patzicia and 18% in Chimaltenango of women of reproductive age reporting use of a contraceptive method.
- In Patzicia, the percentage of women reporting that they selected or had a role in selecting their family planning method climbed by 38 percent; in Chimaltenango the increase was 12%.
- In both communities, at the onset of the project, women's ability to calculate the length of the menstrual cycle was almost nil; at the endline it was 69% in Patzicia and 66% in Chimaltenango.
- In terms of IEC and promotion, in both Patzicia and Chimaltenango, the baseline reported that just over 1% of women knew where to get information about the SDM. At the endline, this figure had climbed to 67 and 66% respectively.

ii. Public Sector

In the public sector, IRH worked with IGGS and the MOH through local consultants and NGOs, including APROVIME and Genesis, whose work is described above.

Social Security Institute (IGGS): In 2005, IRH provided support to the IGGS through a local consultant for six months. The purpose of this consultancy was to consolidate SDM services within IGGS, which first started offering the method in 2003 after receiving training and support from *Calidad en Salud* and IRH. For this consultancy, IRH contracted one of the former members of the *Calidad en Salud* team responsible for providing technical assistance to IGGS on family planning, including the SDM.

Consultancy objectives included SDM training workshops for IGGS personnel, follow-up support and supervisory visits to community service personnel, and technical assistance to those responsible for managing and reporting client data, as well as the distribution of SDM-related materials (CycleBeads, training manuals, provider job aids, etc.). This consultancy resulted in the training of different levels of providers at 38 IGGS hospitals and clinics. Participants included 192 community providers and 209 clinic-based providers.

In addition to trainings and follow-up support, the project provided IGGS facilities with SDM counseling guides, training manuals, and provider job aids. Other materials distributed included 1,000 posters, 25,000 flyers, and 38 SDM videos for IGGS waiting rooms. IGGS community providers received hats and T-shirts identifying them as SDM providers. Through July 2005, IGGS reported 685 SDM users.

Several schools of nursing and auxiliary nursing are in the process of integrating the SDM into their pre-service curricula. The work done to test and validate the distance-learning curriculum for SDM providers led to this development. The SDM has been included in the pre-service

training curricula of four nursing schools in Quetzaltenango and Santa Rosa. Efforts to incorporate the SDM in the curricula of additional schools and programs continue.

Through collaboration with *Calidad en Salud* (URC), IRH was able to incorporate the SDM into the national family planning IEC materials used by both the MOH and IGGS. Research conducted in partnership with the MOH in key geographic health areas also served to strengthen interest in the SDM, particularly given that the sites where the research was conducted expressed a strong interest in continuing to offer the method. As a result, health authorities in the geographic areas that participated in the research have opted to include the method in their workplans and budgets for FY 2008.

D. Incorporating the SDM into reporting systems

As an outgrowth of work with the MOH to test the paper image of CycleBeads in a service delivery setting, the three departments where the study took place—Sololá, Quetzaltenango ,and Santa Rosa—integrated the SDM into reporting registers. Later, it was integrated nationally into the reporting and logistics system, known as SIGSA. IRH donated 10,000 CycleBeads, warehoused in the capital, to help jumpstart the system. However, based on interviews with providers at randomly selected clinics in many parts of the country, it is clear that not all providers are aware of the availability of CycleBeads. As discussions and efforts to more widely integrate the SDM into MOH services continue, this is an important point to resolve.

E. Generating commitment of resources to SDM by governments, NGOs, or donor agencies

With decentralization of the health sector, funding is now provided to health areas as block grants, and budget decisions are handled at the area level. Currently, health area directors in three USAID priority areas are committed to budgeting for the purchase of CycleBeads and will write the SDM into the their plans of action.

Past support for the SDM has included integration of the SDM into the IEC materials of the MOH and IGGS. USAID CA *Calidad en Salud* contraceptive technology updates for both MOH and IGGS providers incorporated SDM training. The MOH and IGGS also generously contributed human resources, technical support, and their respective facilities for activities such as trainings, services, and planning meetings.

F. Summary of SDM introduction and expansion experience

The SDM is available through a large swath of the highlands, the region in western Guatemala extending towards the Pacific Coast. This region is more densely populated than the east and has a considerable indigenous population. Many NGOs serve indigenous communities have integrated the SDM into their programs, given the method's cultural and religious appeal among these populations. Through work with the NGOs Belejeb Batz and AMIGAS, IRH arranged for dozens of small NGOs to receive SDM training. Of these organizations, data collected regarding current SDM activities revealed that about 60% continued to offer the method one year after training.

In the public sector, IRH worked with the MOH and IGGS in several departments in the same general geographic area, with the greatest emphasis in Sololá, Chimaltenango, Quetzaltenango, Santa Rosa, and Totonicopan. The MOH included the SDM in its contraceptive norms in 2002 and IGGS did so in 2003. Despite IGGS' one-year suspension of family planning services for political and financial reasons, it has been actively offering the SDM in two hospitals and 26 clinics since restoring services in early 2006.

Because IRH's primary program focus in Guatemala to date has been research, with limited emphasis on scale up, the SDM's availability is limited to a smattering of small to midsized NGOs and public-sector health clinics in a handful of the country's 18 departments. There has been no designated local presence advocating for national scale up, nor have funds been spent on a major IEC effort to generate awareness and demand. Going forward, a more coordinated, intensive effort, addressing all the elements necessary for ensuring integration and sustainability, could likely go a long way towards institutionalizing the method. The country's relatively low contraceptive prevalence, large indigenous population, and rapid uptake of the method observed in operations research studies all suggest that this is a site which merits continued and expanded scale-up efforts in the future.

IV. Challenges

Challenges include:

- Better integration of the SDM into private-sector services, particularly those of organizations such as APROFAM.
- The need for enhanced IEC to create awareness of the new method through a campaign. Additional funding would be needed to conduct a large-scale IEC campaign.
- Cultivation of political and program support at the local level to expand access to the method. Links must be established with organizations and individuals to present a compelling case for expanding access to the SDM. While IRH staff have been able to do this to a limited degree from Washington, fertility awareness-based contraception needs more consistent advocacy at the local level to break through nationally as a legitimate and widely accepted addition to the basket of family planning methods offered.

V. Lessons Learned

The primary lessons to be gleaned from IRH's work in Guatemala relate to the research conducted around service delivery strategies. A distance learning module, evidence regarding the effectiveness of different SDM service delivery tools, and information regarding the most cost-effective supervision strategies for SDM providers can all support scaling-up efforts in Guatemala and other countries.

Another key lesson is that many NGOs are interested in offering the method, but partnering with these organizations is by itself not an effective strategy for achieving a national presence. In essence, the work in Guatemala has consisted primarily of a series of operations research activities and pilot studies that have yielded some valuable information, but neither do these activities constitute an effective approach to scale up. Going forward, if the objective is national

integration into the family planning program, different strategies will need to be adopted and the first step will be gaining the political commitment of the major public-sector and NGO players in family planning. Working with CAs, while desirable, has proven challenging, given their competing priorities and the absence of any clear directive from the USAID Mission that they are expected to support SDM integration in their own activities.

VI. Future Plans

In order to scale up sustainable SDM services nationally, IRH proposes a strategic approach that would address each of the areas mentioned below.

Build Capacity: Emphasis should be placed on developing in-country capacity for providing training and technical assistance among private and public-sector organizations and with the *Calidad en Salud* project using a variety of SDM training methodologies (workshops, on-line, part of a CTU, etc.) that will ensure that the method is integrated. Local NGOs should be designated to train trainers and providers and to give follow-up support to other NGOs whose staff have been trained, including medical/nursing association networks, community-based, national (i.e., APROFAM) and international (Catholic Relief Services) NGOs. In addition, these focal NGOs should develop memoranda of understanding, collect service statistics, and provide long-distance monitoring to other organizations offering the SDM in Guatemala. Continued incorporation of the SDM training into pre-service nursing/auxiliary nursing school curricula, in partnership with the MOH, will also build sustainable capacity.

Expand Access: Wide-scale training is necessary to achieve national availability of SDM services. IRH successfully tested a low-cost, distance-learning training module with MOH and IGGS providers in 2006. IRH will discuss this strategy with *Calidad en Salud*, and with their support, negotiate with both groups to use this methodology on a larger scale. While the module will not satisfy all training needs, it can play an important role in complementing other activities, thereby reaching higher total numbers of providers trained.

IRH anticipates that the distance-learning approach could be widely used in the private sector, particularly with those NGOs subcontracted by the MOH to provide clinic- and community-based services. A facilitator can oversee implementation of the self-study course with minimal effort. The designated national resource NGO will be responsible for collecting and evaluating materials and the final exam. Those participants demonstrating the requisite level of knowledge/skill will be certified as SDM providers by the resource NGO.

Assure Quality: The KIT and other supervision tools will be used to monitor SDM, TDM and LAM provision and guide follow-up training and assistance targeted at the deficiencies identified. Organizations offering the method will have in-house SDM coordinators qualified to apply the KIT to providers. Studies have documented KIT's effectiveness in peer-to-peer applications, an alternative approach that organizations can use to ensure quality of SDM services. Baseline, midline and endline evaluations will be conducted to measure progress, achievements, and provide feedback to local partners.

Build Political Support: Continued political support for the SDM will be nurtured among government, missions, CAs, and other donors and service delivery organizations. IRH will organize a strategic planning workshop, in collaboration with *Calidad en Salud*, involving key players from the reproductive health community and resulting in an action plan for achieving sustainable SDM services in Guatemala. IRH's country representative, who will facilitate this meeting, has worked at the MOH and *Calidad en Salud*, is well connected with key decisionmakers, and very familiar with the issues.

At the local level, the MOH invited IRH to present to decision makers in the priority health geographic areas to support the inclusion of the SDM in annual workplans and budgets. As the new government is taking possession of power in 2008, IRH will work closely with *Calidad en Salud* to ensure that the commitment developed by the central ministry of the previous administration, the evidence base, and the tools that have been developed in Guatemala will continue to pave the way for the inclusion of the SDM in regional activities, the purchase of CycleBeads using local funds, and better reporting about SDM users.

Increase Awareness: An IEC campaign is essential to increase awareness of SDM availability. The method has been incorporated into MOH family planning materials in collaboration with *Calidad en Salud*, but this is not sufficient. In order for providers to consistently offer the method, demand must exist. IRH will work with partners and the MOH to determine how such a campaign will be implemented in conjunction with other IEC activities related to other family planning methods.

The strongest constituencies for the SDM in Guatemala are rural women who are largely indigenous and have limited experience with family planning. These women have limited access and inclination to use MOH facilities. As such, community-based strategies will be used to reach this population in coordination with the MOH rural program "Extension de Cobertura", IGSS, APROFAM, and NGOs. Additionally, radio holds significant potential, given its ubiquity in Guatemala and popularity with this audience. A simultaneous visual campaign must be adopted to provide exposure to CycleBeads. Community-based distributors and rural health promoters supported by the public and private sector will be one key strategy in raising awareness about FAM at the community level. Further evaluation of other strategies will be required.

> *"In the community, there's time to understand…In the health centers…people treat you badly because you can't afford to go to a doctor."* **– SDM user voicing preference for community-based services**

To address the ongoing availability of CycleBeads, IRH intends to explore distribution through retail outlets, perhaps in coordination with Population Services International/Pan American Social Marketing Organization with whom IRH is already collaborating on other initiatives in Guatemala and throughout Central America.