

implementation story:



Mobile Outreach Health Service for Women in Rural Guatemala: Overcoming Voluntary Family Planning Barriers



PHOTO CREDIT: Wuqu' Kawoq | Maya Health Alliance

A Nurse explaining a pap smear procedure to a patient during the mobile clinic.

AUTHORS

Dra. Andrea del Rosario Garcia and Dr. Kirsten Austad

CONTACT

contact@wuqukawoq.org

ORGANIZATION

Wuqu' Kawoq | Maya Health Alliance

PARTNERS

Friendship Bridge



MAYA HEALTH ALLIANCE
WUQU' KAWOQ

Background and Context

Guatemala is a small country in Central America that possesses rich ethnic diversity. In addition to Guatemalans of primarily Spanish descent, nearly half of the population is indigenous Maya (Ministerio de Salud Pública y Asistencia Social [MSPAS] et al., 2017). Many indigenous Guatemalans live in poverty due to significant and complex socioeconomic inequalities between indigenous and nonindigenous Guatemalans that limit their access to basic health care, including reproductive health care.

Many indigenous Guatemalans are monolingual in one of the more than 20 indigenous languages spoken in the country. Yet public health services do not routinely offer care in indigenous languages and few health care professionals are of indigenous descent. Linguistic and cultural barriers are most apparent for services dependent on counseling, such as voluntary family planning (Nandi et al., 2020). However, over half of Guatemalans live in rural areas—the highest percentage in Central America—with limited access to public transportation needed to access care.

The government is mandated by the constitution to provide free health care to Guatemalan citizens and provides more than half of the voluntary family planning care in the country (Avila et al., 2015). The public health system is, however, severely under-resourced and understaffed. The result is long wait times and medication stockouts in public facilities. Those with financial means choose to seek higher-quality medical care in the private sector, whereas the vulnerable indigenous populations are left without an alternative, even though they perceive care to be of poor quality and place little faith in the public system (Avila et al., 2015).



“Shared decision making is an excellent way of helping women find the best family planning option for them. A method that fits their necessities and their family’s situation, without interfering with their personal beliefs.”–

Yolanda Juarez, Nurse Manager of the Health for Life Program

The end result is a strong distrust arising from these linguistic, cultural, geographic, and quality barriers. Given these barriers, many Maya women often present for emergency care only and not preventive care such as voluntary family planning. Indeed the use of family planning among indigenous women is low (50 percent) compared to nonindigenous women (70 percent) (MSPAS et al., 2017).

THE HIGH IMPACT PRACTICE

Wuqu' Kawoq|Maya Health Alliance is a nongovernmental organization that works with some of Guatemala's most vulnerable communities to provide health care and education in Mayan languages. The program used the [Mobile Outreach Services](#) high impact practice to break down barriers to voluntary family planning access (High-Impact Practices in Family Planning, 2014). Specifically, the women's health program designed a novel mobile outreach service in partnership with Friendship Bridge, a nonprofit microfinance organization dedicated to bringing economic opportunity to rural Guatemalan women. Our team of highly trained nurses offer a package of preventive health services in their clients' homes, including voluntary contraception counseling and immediate provision of an array of contraceptive methods. Since its inception in 2015 the program has served over 9,000 patients and has expanded to five of Guatemala's geographic departments including Sololá, Chimaltenango, Quiché, Quetzaltenango, and Mazatenango.

We have designed a novel mobile outreach service delivery program to help women overcome the geographic and cultural barriers that Guatemala's most vulnerable women face when accessing voluntary family planning and planning their reproductive futures by bringing care closer to them. For the past five years, our partnership with Friendship Bridge enables our program to reach their clients and provide this preventive health care exclusively to them. By doing so, Friendship Bridge provides connections to an existing network of rural underserved women, the population with the highest unmet need for contraception in Guatemala (Colom et al., 2018).

Implementation Story

Nurses provide the majority of voluntary family planning care, which is not only more economically sustainable compared with the higher costs of paying medical doctors, but working with nurses also allows us to recruit indigenous Maya personnel. They offer in-home contraception counseling and immediate provision of a wide variety of contraceptive methods including the hormonal and copper intrauterine devices, the progesterone implant, injectables, the pill, and condoms. Nurses are paid a monthly salary, similar to the public health sector, and are fluent in the Mayan languages spoken by their clients. The knowledge of the language paired with a shared decision making approach to voluntary family planning counseling, reinforces women's autonomy in making their own reproductive health choices. Clients who have been part of Friendship Bridge for three or more years do not pay for contraceptives, but a small number of clients pay a nominal fee equivalent to US\$19 for one year of the contraceptive of their choice.

Jeany Tzoc, one of our field nurses who is Maya Quiche, recently mentioned how satisfying it is to have voluntary family planning counseling sessions with her patients: "The women express gratitude for the detailed information, they feel empowered with the information and this often leads to choosing a voluntary family planning method, which best suits them." Nurses are supported by a nurse program manager and physician. Our team of nurses—consisting of 17 field nurses and 3 supervisors—are in the field 60 percent of the time.



Isabela, a field nurse from Sololá, waiting for a mini bus that will take her to her next home visit.

PHOTO CREDIT: Wuqu' Kawoq | Maya Health Alliance

Rigorous nurse training has been vital to the program's success. Our training materials are based on [WHO's Family Planning: A Global Handbook for Providers](#) to ensure clear, evidence-based information is transmitted to patients (WHO, 2018). We have supplemented this with our own curriculum on shared decision making, a counseling approach that prioritizes women's autonomy (Nandi et al., 2020). Nurses receive extensive training in communication techniques to help each woman clarify her reproductive goals, elicit her unique preferences, and guide her to a "best fit" method. The training itself consists of a three-day classroom training that includes role-playing and values clarification exercises.

The impact of our mobile service delivery approach on patients is evident by comparing our programmatic data to national averages. Overall, use of contraception among patients of reproductive age in our program is 35 percent compared with 36 percent nationally. This is significant because the national percentage is based on the total use of contraception in both the private and public sectors. Additionally, our rate of long-acting reversible contraception (LARC) use is significantly higher—50 percent last year compared with only 4 percent nationally—for rural regions (MSPAS et al., 2017). Qualitative interviews with our clients suggest that trust in the provider and assurance that LARCs will be removed if patients are unsatisfied are important reasons for this trend. Patients reveal that they value the one-on-one counseling provided by nurses and follow-up to ensure they are happy with their chosen method (Austad et al., 2018). Since follow-up plays an important role in building trust and ensuring continuation of the method, our protocols dictate a six-week follow-up call or visit, followed by a six-month follow-up, and a yearly visit thereafter. In most cases, a phone call will suffice, but in-person follow-up is preferred for LARCs in order to look for proper placement and signs of infection.

A recent home visit to one of our patients using a LARC proved how important it is for patients to trust their nurse and the information they provide. This particular woman, a 27-year-old mother of an 18-month-old baby, was having confusing symptoms and was convinced they were due to her contraceptive method. After a one-hour visit, the nurse answered her questions and she was no longer worried her contraceptive implant was making her ill. This experience had a satisfying outcome for both the nurse and her, making the relationship between the patient and caregiver stronger. Our nurses report satisfaction from gaining patient trust, which makes their work meaningful on a personal level. They also value the professional development that goes hand-in-hand with their independence in the field. In particular, they acknowledge the challenges of learning the shared decision-making approach to counseling, and after seeing the impact, they value the skill.

Providing care in rural areas comes with a number of challenges. For example, nurses must locate patients' homes without formal addresses in rural villages. To address this, the program supports nurses with technology that enables them to locate patients' homes and document their visits in a cellphone-based electronic medical record system. Additionally, a participant from the Friendship Bridge communal banks serves as a community liaison, showing nurses to each patient's home (Colom et al., 2018). These community liaisons also advise nurses on local informal transportation networks to reach each village. Nurses participate in monthly educational meetings implemented by Friendship Bridge facilitators, where they offer health services and plan home visits.

Another challenge has been developing a system for field-based supervision as we expand our areas of intervention. This has been a challenge because it requires field visits and hands-on experiences in the company of more experienced health care providers. Despite these challenges, field-based supervision has been key to helping nurses develop communication skills and provide ongoing feedback on their technique for LARC placement and removal. Nurse supervisors who are more experienced within the program and who are themselves Maya women, serve as the supervisors, accompanying nurses to villages and providing real-time feedback without disrupting the nurse-client interaction.



"OUR PATIENTS ARE VERY THANKFUL FOR OUR PATIENCE DURING COUNSELING. THEY ADMIRE OUR WAY OF COUNSELING THROUGH THEIR DECISION AND LIKE VERY MUCH THAT WE SHARE ADVANTAGES AND DISADVANTAGES OF FAMILY PLANNING METHODS."

Jenny Bartholomin, Nurse Supervisor for Quiche and Chimaltenango



"SHARED DECISION MAKING HAS BEEN A TOOL TO BREAK DOWN MYTHS AND TABOOS AROUND FAMILY PLANNING FOR WOMEN. IT IS A GREAT WAY TO FORM A SPECIAL BOND WITH OUR PATIENTS."

Rebeca Gonzalez, Nurse Supervisor for Quetzaltenango and Sololá



A field nurse from Quiche walking with a patient to her home for the mobile clinic.

lessons learned and recommendations

01 Mobile services alone are not sufficient to increase uptake of contraception, but they must be paired with high-quality counseling and nonjudgmental guidance:

Implement a shared decision-making counseling training curriculum.

Include interactive values clarification exercises to ensure nurses promote an unbiased and nonjudgmental approach to contraception.

Support nurses in the field not only through classroom training, but also applying knowledge and supervision during field visits.

02 Home-based care requires tailoring to the local culture:

Recruit nurses from the population being served.

Prioritize service delivery in the local language.

03 Innovative approaches to provide longitudinal follow-up after mobile clinics is key:

Nurses should conduct routine follow-up telemedicine visits after LARC placement to resolve patient doubts, proactively treat side effects, and support patients' continued use of the method.

If possible, conduct home visits for follow-ups, especially when nurses are from the population being served. This makes communication stronger with patients when telephones are not always available.

Use electronic medical records to keep track of clients. This detailed information provides a monthly list of women who are due for follow-up.

04 Systems for quality control must be in place:

Supervisors should regularly accompany nurses to reinforce a culture of continuous skills improvement among field nurses.

Implement an appropriate train-the-trainer curriculum to achieve better results during field visits.

Field nurses should call program physicians when issues in the field exceed their scope of knowledge.

Share photo-documentation of voluntary family planning procedures—such as sharing a picture six weeks after insertion of a contraceptive implant to ensure it was placed at an appropriate location and depth—to help ensure competency of field nurses. Upload the photos to a secure online cloud service where program physicians can review and provide feedback.

05 High nursing turnover places strain on the program:

Carefully recruit nurses interested in providing community-based care.

Create standardized onboarding processes to ensure new nurses have the necessary equipment and knowledge to rapidly start in the field.

Include continued training and learning opportunities to improve nurse performance, self-confidence, and make it appealing for them to continue their work.

06 Proactively plan for the safety of field nurses:

Nurses should travel in pairs in communities with high crime rates.

Arrange for community members to accompany nurses.

Shift safety procedures as needed. For example, during the COVID-19 pandemic, we have shifted to the use of private transportation—paid for by program expenses in the form of a company car or taxi—to enable nurses to avoid crowded areas and continue visiting communities despite public transportation lockdowns.

07 Active data monitoring systems can help identify problems in the program rapidly:

Rapidly review and analyze electronic medical records to assess visit volume and performance metrics.

Plan for periodic analysis and assessment of results with team leaders to identify issues and shift accordingly.

REFERENCES

Austad, K., Shah, P., & Rohloff, P. (2018). Correlates of long-acting reversible contraception uptake among rural women in Guatemala. *PLoS ONE*, 13(6), 1–11. <https://doi.org/10.1371/journal.pone.0199536>

Avila, C., Bright, R., Gutierrez, J. C., Hoadley, K., Manuel, C., Romero, N., & Rodriguez, M. P. (2015). Guatemala: Health System Assessment 2015. August, 1–164. https://www.usaid.gov/sites/default/files/documents/1862/Guatemala-HSA_ENG-FULL-REPORT-FINAL-APRIL-2016.pdf

Colom, M., Austad, K., Sacui, N., Larson, K., & Rohloff, P. (2018). Expanding access to primary healthcare for women through a microfinance institution: A case study from rural Guatemala. *Healthcare*, 6(4), 223–230. <https://doi.org/10.1016/j.hjdsi.2017.12.003>

High-Impact Practices in Family Planning (HIPs). (2014). Mobile outreach services: expanding access to a full range of modern contraceptives. USAID. <http://www.fphighimpactpractices.org/briefs/mobile-outreach-services>

Ministerio de Salud Pública y Asistencia Social (MSPAS), Instituto Nacional de Estadística (INE), & Secretaría de Planificación y Programación de la Presidencia (Segeplan). (2017). Informe Final. VI Encuesta Nacional de Salud Materno Infantil. ENSMI. 748. https://www.ine.gov.gt/images/2017/encuestas/ensmi2014_2015.pdf

Nandi, M., Moore, J., Colom, M., Del Rosario Garcia Quezada, A., Chary, A., & Austad, K. (2020). Insights into provider bias in family planning from a novel shared decision making based counseling initiative in Rural, Indigenous Guatemala. *Global Health Science and Practice*, 8(1), 10–17. <https://doi.org/10.9745/GHSP-D-19-00377>

WHO. (2018). Family Planning - A global handbook for providers: 2018 Edition. WHO. <https://www.who.int/reproductivehealth/publications/fp-global-handbook/en/>