

New Training Strategies for Expanding Access to the IUD in Guatemala

Background

Guatemala is an ethnically diverse, high-fertility country in Central America. With a population of about 12.7 million and a total fertility rate of 4.4, Guatemala is one of the most rapidly growing countries in Latin America (PRB, 2005). As of 2004, the contraceptive prevalence rate for modern methods was only 34%, about two-thirds that of the region as a whole, and the percent of IUD use was only 2.2. At the same time, unmet need for contraception among women was 23%.

The Ministry of Health (MOH) is currently trying to increase the availability and use of the IUD in rural areas as a safe long-term method for birth spacing. Its key strategy is the implementation of a program to train auxiliary nurses to provide IUD insertion and removal, along with other reproductive health services, especially in rural areas.

Organization of Services

There are three main service providers in the field of reproductive health: the Guatemalan Ministry of Health and Social Assistance (MSPAS), the Guatemalan Institute of Social Security (IGSS), and APROFAM, a nongovernmental family planning organization. All three provide some level of IUD service, and the IUD most commonly used is the Copper T380A.

As the service provider data from 2002 in Table 1 illustrate, APROFAM is by far the largest provider of IUD services in Guatemala. IGSS also offers IUD services although it provides a much smaller number of IUDs overall and these users tend to be more concentrated in urban or semi-urban areas. Furthermore, both IGSS and MSPAS provide IUDs to a very small number of their new clients overall (Brambila and Taracena 2003).

In addition, some counselors and physicians who are eligible to provide IUD services lack the knowledge to do so, leading to low quality of care for IUD users. For example, providers are familiar with only about half of the topics to be covered during counseling and case management (Brambila and Taracena 2003). This reflects not only providers' lack of

knowledge, but also the distrust that many of the rural health professionals have for IUDs based on old information, outdated models, and popular rumors.

Table 1: IUD Provision in Guatemala

Organization	Total Number of IUDs Inserted	Number of IUDs Inserted by Rural Providers	Percentage of New Clients Who Receive IUDs
MSPAS	3,573	51	3.1%
IGSS	1,965	292	6.2%
APROFAM	5,585		14.7%

Source: Brambila and Taracena 2003, p. 7-10

New Training Model Tested

In an attempt to address these circumstances, the MOH, with the support from the USAID bilateral agreement, Quality in Health Program, launched a training program certifying nurse auxiliaries to offer IUD services (both insertion and removal), take pap smears, and provide DMPA. The training consisted of a two-day informational course and on-site practical training under the supervision of a qualified trainer (Vernon et al. 2005). The training was conducted in two phases as part of a strategy to scale-up to priority health areas in the country. In each area the service delivery model was the same.

- Auxiliary nurses were trained in IUD counseling, insertion, and removal; case management; DMPA injection; and pap smears. This training increased the number of qualified providers in an attempt to equalize the gap between facilities and trained personnel. The addition of newly qualified providers also eases the heavy caseloads that prevent physicians from providing IUD services, and it alleviates the lack of IUD knowledge that is common among staff in many clinics.
- The Auxiliary nurse training program requires that the nurse be trained in her own service site. This allows the nurses to become familiar with their own clinics' equipment and clientele as they are learning. In addition, nurses are required to have completed five insertions under the guidance of a qualified professional before they are certified.
- The training was supported by a series of materials designed to standardize the package of services and health messages provided. Support materials included client job aids; an IUD service delivery manual; and brochures, posters, and leaflets for clients.
- In addition, a manual was produced to explain how to implement a strategy to inform community members about the IUD.¹ The manual recommends providing IUD information to all clients and asking them to distribute leaflets among friends and neighbors who might be interested in the method. Other recommendations include giving two-minute talks to clients and community members, about message on the new availability of the method; handing out

Ministry of Health, APROVIME and FRONTIERS in Reproductive Health, Population Council. 2004. Estrategias para ampliar el acceso a la T de Cobre (DIU). Guatemala, June.

a leaflet or brochure to those who might be interested in the method; placing posters throughout the community; and organizing and conducting special one-day events (called *jornadas* in Spanish) on the IUD and other health topics.

- A total of 90 service providers from 68 health districts in nine health areas achieved certification. These included 8 physicians, 26 professional nurses, 48 nurse auxiliaries in health centers, and 8 nurse auxiliaries in health posts. During the first year of activities, when training was also provided to nurse auxiliaries in health posts, 86% of the providers who began group training achieved certification. In the second year of activities, only about one-third of the nurses and nurse auxiliaries who began theoretical training achieved certification. This was the result of more stringent requirements regarding the number of clients needed to have the trainer/supervisor visit the trainee and, more importantly, lack of adherence to the requirement of the models by district chiefs.
- A total of 725 IUD services were provided (301 in the first phase and 424 in the second phase) during training. On average, providers conducted more than six supervised insertions. In the first phase, adherence to the established protocol was nearly perfect after the third insertion. In the second phase, with new job-aids, adherence to the protocol was perfect after the first insertion.

Monitoring and Quality Assurance

To ensure adequate supervision by project staff, a comprehensive supervision guide was developed. The guide described all aspects of IUD service provision, including balanced family planning counseling, information/education/communication activities, installed capacity, provider technical competence, information systems, and logistics. Project trainers and supervisors also used a 34-item observation checklist to assess IUD pre-insertion, insertion, and post-insertion service delivery behaviors. This checklist allowed them to assess the quality of the services provided by the trainee and helped the trainer identify those areas on which the trainee required feedback.

In 31% of the cases, the presence of menstruation had ruled out pregnancy. Current use of an injectable (35%), exclusive breastfeeding in the first three months of an infant (26%), absence of sexual relations since last menstruation (5%), and birth within the last six weeks (2%) were the other criteria used to rule out pregnancy before insertion.

To strengthen supervision capabilities at the MOH, a staff member from the Reproductive Health Department helped to teach each district course and to conduct on-site follow-up training visits. A large number of district chief nurses were also trained in IUD service delivery and in supervising activities using the various job aids produced by the project. Chief nurses were instructed to observe IUD insertions and removals made by trainees during their first three months after certification.

In the second phase of the project, the checklists showed perfect compliance with all itemized procedures on the checklist. This seems to have been the result of using all the job aids that were introduced in this phase, such as the poster showing the 24 steps of the IUD

insertion procedure, the checklist to determine eligibility and rule out pregnancy, and counseling materials.

Results

The results during training were encouraging, with IUD insertions rising dramatically during the course of the intervention. In general, at first-phase health centers and posts, training seems to have improved access to IUD services. These services continued to be provided after the training, although not at higher levels than those observed before the intervention. The contribution to the total number of couple-years of protection (CYP) provided by participating health facilities ranged between 2% and 10%. See Table 2 for a detailed description of training results by health area.

Table 2. Average number of IUD insertions, couple-years of protection* (CYPs) provided by the IUD, and CYPs* provided by all temporary methods delivered by participating health centers and posts before, during, and after training, by project phase and health area

First-Phase Health Areas	Year				
	2002	2003			2004
		Before	During	After	
Chiquimula					
IUD insertions	0.0	5.0	18.8	6.3	1.6
IUD CYPs	0.0	17.5	65.8	22.0	5.6
Total CYPs	555.8	283.1	449.4	690.1	242.0
Months	12	2	4	6	12
Escuintla Health Centers					
IUD insertions	2.9	5.3	17	11.5	4.3
IUD CYPs	10.2	18.4	59.5	40.3	15.1
Total CYPs	122.5	336.9	367.4	339.5	417.3
Months	12	4	6	2	12
Escuintla Health Posts					
IUD insertions	3.2	0	0.3	3.5	3.2
IUD CYPs	11.2	0	1.1	12.3	11.2
Total CYPs	79.4	91.4	77.4	91.9	102.0
Months	12	4	6	2	12
Suchitepequez Health Centers					
IUD insertions	8.7	3	26.3	10.5	6.7
IUD CYPs	30.3	10.5	92.0	36.8	23.3
Total CYPs	378.7	428.0	474.0	334.1	432.9
Months	-12	-3	-7	-2	-12
Suchitepequez Health Posts					
IUD insertions	1.7	0	7.3	2	2.1
IUD CYPs	5.95	0	25.6	7.0	7.4
Total CYPs	115.6	83.5	168.8	70.7	170.9
Months	12	3	7	2	12

Source: Sistema de Información Gerencial en Salud (SIGSA). Form 6.

Table 2 (Continued). Average number of IUD insertions, couple-years of protection* (CYPs) provided by the IUD, and CYPs* provided by all temporary methods delivered by participating health centers and posts before, during, and after training, by project phase and health area

Second-Phase Health Areas	Year				
	2002	2003	2004		
			Before	During	After
Chimaltenango					
IUD insertions	4.3	16.2	17.4	63.0	36.0
IUD CYPs	15.1	56.7	61.1	220.5	126.0
Total CYPs	59.5	239.0	309.1	326.9	381.6
Months	12	12	9	1	2
Jalapa					
IUD insertions	0.2	4.1	4.0	15.8	6.0
IUD CYPs	0.7	14.4	14.0	55.1	21.0
Total CYPs	90.0	120.9	168.4	216.2	145.8
Months	12	12	4	4	4
Jutiapa					
IUD insertions	13.2	7.9	5.5	17.5	3.0
IUD CYPs	46.2	27.65	19.3	61.3	10.5
Total CYPs	205.3	115.0	268.8	157.3	142.8
Months	12	12	6	2	4
El Progreso					
IUD insertions	14.3	32.8	55.8	204.3	33.3
IUD CYPs	50.1	114.8	195.3	715.2	116.4
Total CYPs	169.8	554.3	737.5	1075.3	310.6
Months	12	12	5	3	4
Santa Rosa					
IUD insertions	12.5	38.4	27.0	122.0	40.8
IUD CYPs	43.8	134.4	94.5	427.0	142.6
Total CYPs	344.2	542.1	317.1	501.7	312.8
Months	12	12	6	2	4
Solola					
IUD insertions	1.1	2.7	0.5	6.5	3.5
IUD CYPs	3.9	9.5	1.8	22.8	12.3
Total CYPs	70.0	120.0	80.0	98.3	165.6
Months	12	12	8	2	2

Source: Sistema de Información Gerencial en Salud (SIGSA). Form 6.

*CYPs: 15 pill cycles, 120 condoms, 4 Depoprovera injections, one new standard day method user or 4 new LAM users = each one CYP; 1 IUD = 3.5 CYPs

In second-phase areas, the average number of IUD services provided by participating health centers was higher than that in the pre-intervention period (pre-intervention period is the early months of 2004 in second-phase sites and the 12 months of 2003 in first-phase sites). This increase is especially relevant given the extensive training in IUD services provided by the MOH in 2003 using a more traditional model. In second-phase areas, the percentage of CYPs provided by IUDs after training ranged between 10% and 50% of the total CYPs provided, which suggests that the IUD has a stronger presence in the range of available methods.

The post-intervention observations indicated that the number of new users of IUDs stabilized at a level lower than during the intervention, but was markedly higher than pre-intervention levels (Vernon et al. 2005). This shows that the strategy is an effective tool for increasing access to IUDs for women who desire a long-term method. A follow-up in 2005 indicated that 76% of the providers continue to provide IUD services nearly two years after training, accounting for 30% to 60% of the IUD services in their health areas. Considering all participating service delivery facilities, there is also a clear upward trend in the delivery of all contraceptive services over time. Increased access to the IUD not only yields increased acceptance of IUDs, but also of other methods.

Characteristics of Users

In general, the new IUD services reached a large number of women who were not using contraception, were using ineffective methods, or would need a method soon (such as LAM users). The women were young, poor, with large families, and with low schooling levels. Fifty-two percent of the IUD clients had not completed primary school, and 13% had no schooling at all. Forty percent had four or more children. Fifty-six percent had traveled less than half an hour to visit the health center. Seventy-five percent of the acceptors said they were using a method at the time of acceptance, but more than 20% were using lactational amenorrhea, rhythm, or withdrawal. Twenty-three percent of all clients said they had never used a method. Forty percent of the women said they did not want any more children, and 90% of those that wanted more children preferred to space their next birth more than two years. In short, the providers were reaching women in high need of long-term methods.

Conclusions

Providing training for nurse auxiliaries in their own service delivery sites seems to have had a positive effect on the delivery of contraceptive services, particularly IUD services, at participating health centers and posts. The strategy offers flexibility to local health providers and the community to address the unmet need for spacing.

References

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