international family planning perspectives

Promoting Birthspacing Among the Maya-Quiché

The baseline data were collected from May through August 1992, and the follow-up data, from October through December 1996. The questionnaire for the baseline survey was translated into Quiché, and the follow-up questionnaire was nearly identical to that used at baseline (except for a concluding section with items on male involvement). For both surveys, interviewing was conducted by bilingual Mayan interviewers who were matched with respondents on gender. All interviewers underwent training and field practice, and they were supervised closely.

Multivariate Analyses

Since a pretest and posttest separate sample design does not allow for attribution of effects or permit confounding factors to be ruled out, we conducted multivariate analyses to gain greater insight into the factors associated with the key outcome variable, contraceptive use. It is widely recognized that contraceptive use is influenced by both supply and demand factors. Supply factors are those relating to the family planning supply environment (i.e., the number and type of sources of family planning, the range and quality of services available through those sources, and so on), while factors influencing demand (for both children and services) include social and demographic characteristics, exposure to modern ideas through the mass media and individual reproductive experiences. For this study, we conducted multivariate analyses using 12 independent variables—three supply (or contact) variables and nine demand variables—to identify the determinants of contraceptive use.

The variables for program contact were APROFAM clinic attendance, receipt of a promoter visit and attendance at a Ministry of Health facility. The demand factors included the respondent’s age, education, comprehension of Spanish, employment outside the home, number of household amenities, exposure to birthspacing messages (through any of four channels—radio, television, loudspeaker and community health worker), experience of a mistimed pregnancy, number of living children and husband’s education (not shown).

To determine the relative importance of each of the supply and demand factors in predicting contraceptive use, we tested a series of variables as predictors of current use at the 1992 baseline survey and at the 1996 follow-up survey; we also tested for interactions. If, for example, social and demographic factors were the only significant predictors of use at both points in time, one would have to question whether the Guatemalan family planning program had any role in influencing contraceptive use in this population.

Program-Based Results

Availability of Services

The routine service statistics compiled by APROFAM for the years corresponding to the project and data from the intervention records show several trends. First, the number of promoters grew from 79 in 1993 to 144 in 1995. There was relatively little change in the number of other service delivery points, either clinics or health centers or posts, over the period 1993–1995.

The proportion of volunteer promoters serving this area who were Mayan increased over the life of the project, from 24% in 1993 to 49% in 1995, thus increasing the number of service delivery points with personnel able to speak Quiché. Even so, by the end of the pilot project, fewer than three-fifths of the promoters (58% in 1995) were bilingual in Spanish and Quiché.

The number of methods the promoters (or the other service delivery outlets) provided changed very little from 1993 through 1995: The APROFAM clinic offered six methods in every year (pills, IUDs, injectables, condoms, female sterilization and vasectomy). While the promoters offered their clients three methods over the life of the project (pills, condoms and spermicides), the Ministry of Health delivery points provided these same three methods in 1993 and 1994, but only pills and condoms in 1995.

Use of Services

In terms of couple-years of protection generated by APROFAM over the three years, those delivered in a clinic setting accounted for the large majority (88–89%, see Figure 1). Also, although the volunteer promoters generated a far lower proportion of the total couple-years of protection each year (the remaining 11–12%), this source is still important for programmatic reasons, since promoters reach users in

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*The sampling procedure changed because a different organization provided technical oversight with the follow-up survey, and these data were also intended for additional uses (i.e., to evaluate male involvement in family planning) that are not relevant to the current analysis.

†The ideal evaluation design would have been a true experimental design, involving pretest and posttest measurement in two randomly allocated groups. However, since this type of “true experiment” is virtually impossible to carry out (given the need to randomly allocate subjects to experimental and control populations), the next best alternative would have been a quasi-experimental design, with a pretest and posttest nonequivalent control group (see reference 7). The latter design could not be used in our study because we lacked an “equivalent population” that would not have been exposed to radio messages diffused as part of the intervention.

‡Pharmacies were yet another source of contraceptives. Six of the eight communities had at least one private pharmacy; in these six towns, the number of pharmacies ranged from three in the smaller towns to eight in the main city of El Quiché, Santa Cruz del Quiché. The large majority of these pharmacies carried pills, condoms, spermicides and (less frequently) injectables.