Revitalizing Lactational Amenorrhea Method (LAM) Services in Burkina Faso and Mali

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The *Institute for Reproductive Health* 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 of 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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EXECUTIVE SUMMARY

In 2006, the United States Agency for International Development (USAID) gave the Institute for Reproductive Health (IRH), Georgetown University the mandate to resume work in the Lactational Amenorrhea Method (LAM), which IRH had developed under a prior cooperation agreement, with an emphasis on revitalizing LAM in settings where the method previously had been introduced but was not reaching its potential.

Technical strategies to achieve this revitalization of LAM included:

- repositioning LAM as a gateway to other family planning methods, by emphasizing the timely transition to another modern method when the woman is no longer eligible to use LAM, or earlier if she so chooses;
- simplifying messages to clients, including simpler instructions, with a strong emphasis on exclusive breastfeeding;
- streamlining teaching and training by focusing on core content, reducing the number of messages, simplifying messages, and limiting the number of manuals, tools, and aids to be used by trainers and by service providers;
- broadening the range of services which offer LAM developing materials for and providing technical assistance (TA) to different types of programs, including family planning, antenatal, maternity, postpartum, maternal and child health (MCH), and others.

IRH developed instructional materials, job aids, and materials for clients, which incorporated these strategies, and planned projects to pilot test the approach and the materials. Countries selected to carry out these pilot projects were Burkina Faso, Mali, and India (see separate report for India project). Although LAM had been introduced to Burkina and Mali in the 1990s and was included in the family planning norms in both countries, LAM services were no longer available on any significant level, there were almost no users, and the method had been practically dismissed as a family planning option.

After considerable advocacy to overcome the initial skepticism of policymakers and other key gatekeepers in both countries, IRH began activities in late 2006. By working through local partners, IRH trained core groups of Ministry of Health (MOH) trainers, supervisors and selected providers, who then trained providers from selected areas in Burkina, where IRH worked in close collaboration with JHPIEGO, and in Mali. There has been a visible impact in areas where LAM services became available soon after these trainings. In Burkina over 600 women received LAM counseling; and there was also a noticeable increase of users of other family planning methods, particularly injectables and oral contraceptives, in the facilities where LAM service were available. Field information from Mali shows that significant numbers of women are choosing LAM and receiving counseling on it.

Expansion of LAM services to other areas of Mali is already underway, with continued (TA) from IRH to the MOH, including TA to strengthen some support systems. Expansion to other areas of Burkina is contingent on availability of resources.

The data and other information obtained from these two pilot projects can be the base for expansion of LAM services to other parts of Burkina and Mali. The information, together with the lessons learned here can also be presented to policymakers from other countries, cooperating agencies, international organizations, and others, as evidence that repositioning LAM as a gateway to other modern family planning methods is of interest to policy makers and that the proposed technical strategies are viable.

LIST OF FIGURES AND TABLES

ACRONYMS

BCC	Behavior Change Communication
IEC	Information, Education, Communication
CSComs	Community Health Centers
CSRefs	Reference Health Centers
CYP	Couple Years of Protection
DHS	Demographic and Health Survey
DRS-Koulikoro	Regional Health Directorate in Koulikoro
GOM	Government of Mali
HIHS	High Impact Health Services
HTSP	Healthy Timing and Spacing of Pregnancies
IRH	Institute for Reproductive Health
LAM	Lactational Amenorrhea Method
M&E	Monitoring and Evaluation
MIS	Management Information System
MNH	Maternal and Neonatal Health
MOH	Ministry of Health
PMTCT	Prevention of Mother-to-Child Transmission
SDM	Standard Days Method®
SSA	Sub-Saharan Africa
TA	Technical Assistance
TOT	Training of Trainers
USAID	United States Agency for International Development
WHO	World Health Organization

1. INTRODUCTION

The Lactational Amenorrhea Method (LAM) is a natural family planning method based on a woman's normal infertility resulting from breastfeeding. A woman will be effectively protected from pregnancy if she meets ALL the three LAM criteria:

- She is still in postpartum amenorrhea, AND
- She is fully or nearly fully breastfeeding the child, AND
- The child is less than six months old.

The effectiveness of LAM was demonstrated in clinical trials[1], and confirmed in other studies and in programmatic use. As long as all three criteria are met, the method is more than 98% effective.

Women who meet the three criteria and want to use LAM as their family planning method are encouraged to continue breastfeeding their child as much as possible, giving him/her no more than occasional sips of liquid or very small amounts of food (a simplified definition of "almost fully" breastfeeding). They are instructed to return to the provider when they stop meeting any of the three criteria. The importance of using another appropriate family planning method as soon as she no longer meets any one of the three LAM criteria should be emphasized during initial counseling and at any subsequent contact with the provider.

LAM can be particularly important for the sub-population of women who have not been using modern contraception. Evidence suggests that LAM users are more likely than non-LAM users to become new acceptors of other modern methods. A study in Jordan measured the transition from LAM to another modern method at one year postpartum and suggests that LAM attracts previous non-users to the modern method mix[2].

LAM can have important benefits in several areas including:

- It can provide effective contraceptive protection to postpartum women.
- It can help women transition to another modern family planning method.
- It can help women improve their breastfeeding practices, including help HIV+ women continue breastfeeding practices (i.e. exclusive breastfeeding through the first six months followed by weaning and transition to appropriate infant feeding[3]) that improve prevention of mother-to-child transmission (PMTCT) of the virus.

LAM was developed and tested by the Institute for Reproductive Health (IRH) at Georgetown University in the late 1980s and early 1990s and has been available to service delivery programs for well over a decade. As one result of several USAID-funded and other programs, LAM is included in all four World Health Organization (WHO) cornerstone documents (*Medical Eligibility Criteria for Contraceptive Use,*

[1] Perez A, Labbok M, and Queenan J. 1992. Clinical Study of the Lactational Amenorrhea Method for Family Planning. *Lancet,* 339 (4): 968-70.
[2] Bongiovanni, A. et al. 2005. Promoting the Lactational Amenorrhea Method (LAM) in Jordan Increases Modern Contraception Use in the Extended Postpartum Period. The LINKAGES Project, Academy for Educational Development.
[3] Piwoz E, et al. 2007. The Impact of Safer Breastfeeding Practices on Postnatal HIV-1Transmission in Zimbabwe. American Journal of Public Health, Vol. 97, No. 7: 1249-1254.

Selected Practice Recommendations for Contraceptive Use, Decision-Making Tool for Family Planning Clients and Providers, and Family Planning: a Global Handbook for Providers), in most family planning documents and materials (including general information, training tools, service delivery tools and job aids, and other resources), and in the norms and/or technical guidelines of numerous countries throughout the world. It is widely accepted by those involved in family planning – policy makers, program managers, providers – as a good option for mothers, for children and for programs.

But in spite of this, even though LAM figures as one of the methods officially available in most family planning programs, with the exception of a few countries in the world and specific areas of some countries, it is an underutilized method.

A survey of program managers knowledgeable about or involved in LAM activities was conducted in seven countries (Burkina, Guatemala, Indonesia, Mali, Nepal, Pakistan, Philippines, Tanzania) by IRH and JHPIEGO/ACCESS-FP. Responses to the survey confirmed anecdotal information that:

- LAM services are not really available (although LAM figures in the official list of methods most programs offer).
- Very few women use LAM.
- Although many providers are aware of LAM, they generally prefer to promote and provide other methods they perceive as "modern" and more effective.
- Programs lack enough providers trained in LAM.
- Most providers who do offer LAM are not competent or knowledgeable in the method.
- Policy-makers say they appreciate LAM, but many of them are not knowledgeable about it, and their decisions show they prefer other methods.
- LAM is included in the pre-service curricula of some schools of nursing, midwifery and medicine, but in general it is not being taught to students.

Reasons sometimes mentioned by high- and mid-level decision makers for not seeking a larger role for LAM in their programs include:

- the perception that LAM is not as effective as other modern family planning methods,
- the fact that each LAM acceptor only credits 0.25 couple years of protection (CYP) for the program,
- the perception that training providers in LAM demands significant amounts of program resources including providers' time, and
- the perception that many of the training and service delivery resources in existence (manuals, job aids, and other tools and materials) focus too much on breastfeeding-related knowledge and skills and not enough on contraceptive protection, including the timely transition to other modern family planning methods.

With all this in mind, IRH, together with other organizations, including JHPIEGO/ACCESS-FP, developed a strategy to revitalize LAM services, focusing on pilot efforts in selected countries to test materials, assess policy-maker support, and establish the feasibility of the approach.

2. PROGRAM STRATEGY

The goal of the project was to revitalize LAM, by making quality LAM services effectively available in more large-scale health programs in Burkina Faso and Mali through pilot studies which could provide information on which to base future LAM expansion.

The overall strategy was to reposition LAM as a gateway to other modern family planning methods. This included emphasizing the timely transition from LAM to other modern family planning methods in training and service delivery activities and materials, program support tools, behavioral change communications (BCC) and monitoring and evaluation (M&E). It also included a focus on healthy timing and spacing of pregnancies (HTSP).

IRH developed training, service delivery, BCC, and programmatic approaches, procedures and tools that make LAM easy to train providers, learn and use (clients) - simplifying and reducing the number of messages to clients, and streamlining training and service delivery.

IRH worked with different types of programs, including family planning and maternal, neonatal, antenatal, postpartum, and community health to implement LAM services.

Successful implementation of these strategies required the support of key stakeholders, including organizations and individuals involved in initial LAM development and testing, WHO, UNICEF, other international organizations, U.S. Agency for International Development (USAID), cooperating agencies, and others. To obtain this support it was important to achieve consensus that repositioning LAM as a gateway to other methods was a valuable strategy, and to present evidence that these strategies were evidence-based and feasible to implement at the field level.

An important characteristic of this approach to LAM is that it builds on the goal of HTSP, and functions in the context of informed method choice. If a postpartum women, after being offered all methods available for which she is eligible, chooses to use LAM, the LAM counseling she receives covers more than just specific information on how to use the method. Counseling also includes HTSP messages, and clients are urged and supported to begin considering which family planning method they will use when they stop using LAM. If programs schedule a follow-up visit, the eventual transition to another modern method is one of the focal areas of that visit. The goal is that when her fertility returns, she will have already chosen her next method, making it more likely that she will begin using it right away. See Appendix A: LAM Job Aid for Providers.

Messages to clients are fewer and simpler than those used in previous LAM initiatives. They include simpler instructions on desirable breastfeeding patterns for LAM, with a very strong emphasis on *exclusive* breastfeeding ("… do not give your child any liquids or foods other than your breastmilk…."); simpler instructions regarding amenorrhea ("… contact your provider if you notice *any* vaginal bleeding after two months postpartum…"). See Appendix B: Client card for LAM users.

Training of trainers and providers was shortened, focusing on basic aspects of LAM use and how to support women to choose their next family planning method while they are still eligible to use LAM and start using it as soon as they stop using LAM. Training for trainers and supervisors addressed programmatic issues related to ensuring that postpartum women was presented with all appropriate family planning options, that the focus of LAM counseling was on the transition to other methods, and that providers were prepared to provide these other methods (or refer clients for these services).

3. LAM PILOT PROJECTS

3.1 Importance of LAM in Burkina Faso and Mali

Poor reproductive health in Sub-Saharan Africa (SSA) has contributed to some of the world's highest infant and maternal mortality rates, as well as a loss of human capital contributing to stagnant economic growth and increased poverty. While total fertility has been declining globally over the past 15 years, women in most SSA countries still have between five and seven children—nearly twice that of their counterparts in the rest of the world. Burkina Faso and Mali are representative of the reproductive health crisis in the region. The two countries have high unmet need for family planning (28% in Burkina Faso and 29% in Mali according to the most recent demographic and health survey)[4]. Potential demand for natural methods of family planning is also high in both countries. Including LAM in the method mix can serve as an "entry point" for stimulating the use of other modern methods in countries like Burkina Faso and Mali where fertility is high and contraceptive prevalence is low.

The primary impediments to modern contraceptive use by women and men in Burkina Faso and Mali include lack of information about family planning and access to health facilities. For example, the average distance to a health centre in Burkina Faso is ten kilometers[5]. The majority of the Malian population lives in traditionally underserved rural areas. Malian and Burkinabe women frequently hesitate to use family planning due to cultural beliefs and taboos, fear of side effects (real or perceived), community expectations for bigger families and/or personal fertility preferences.

Although breastfeeding is nearly universal in Burkina Faso and Mali, its contraceptive benefit is not well known. Many women are unaware that breastfeeding can act as a contraceptive. Existing programs focus mainly on the nutritional benefits of breastfeeding and ignore the contraceptive benefits.

In July 2006, USAID asked IRH to reinvigorate LAM services. Burkina Faso, Mali and India were selected as sites appropriate for pilot testing the approach proposed by IRH (see separate report for India). The overall strategy was in line with the Burkina Faso National Safe Motherhood program that was supported by the United States Embassy and aimed to improve quality and accessibility of care to women during pregnancy,

[4] Population Reference Bureau. 2004. *2004 World Population Data Sheet*. Washington, D.C.: Population Reference Bureau.

[5] Direction Nationale de la Statistique [Burkina Faso]. 2000. *Enquête Démographique et de Santé, Burkina Faso, 1999*.: Direction Nationale de la Statistique.

delivery and post partum. It was also in line with the new USAID/Mali 2003-2012 High Impact Health Services (HIHS) strategic framework, which supports the government of Mali's ten-year health and social development plan. In Burkina Faso, LAM efforts were supported by IRH/Georgetown and ACCESS-FP and implemented by JHPIEGO/Burkina Faso and the Ministry of Health (MOH). In Mali, activities were supported by IRH and implemented by the provincial MOH office in Koulikoro.

IRH has worked in Burkina Faso since August 2002 when the Standard Days Method® (SDM) of family planning was introduced through a pilot study. In cooperation with JHPIEGO, IRH started working in 2006 to reintroduce LAM to Burkina. IRH has been working in Mali since August 2006 when USAID/Mali allotted funds for IRH to help the MOH and other partners to integrate the SDM and LAM into the method mix. With interest and support from the MOH, IRH started working to scale up the SDM nationally, while piloting LAM in one area.

4. LAM PROJECT IN BURKINA FASO

4.1 Background

Burkina Faso has an estimated unmet need for family planning of 28%, of which 22% is related to birth spacing. There is also a potential demand for family planning of 43%, of which 32% is for birth spacing[6]. Close to 90% of all women are illiterate, the overwhelming majority in rural areas. With an annual growth rate of 3%, the total population is expected to reach 23 million by 2025 [7]. Limitations to contraceptive use include logistical and cultural challenges of delivering family planning programs, the often poor quality of health services, lack of information about reproductive health issues, differences in economic status, gender inequality, limited contraceptive choices, and poor access to services.

Reinvigorating LAM in Burkina, where breastfeeding constitutes the most common infant feeding practice, could significantly contribute to increased contraceptive prevalence. According to the recent demographic and health survey, around 25% of infants in Burkina Faso were breast fed within an hour of birth, and 44% were breast fed within one day of birth[8].

In September 2006, IRH and ACCESS-FP began working together to reinvigorate LAM by repositioning it as a gateway to other modern methods. This effort was funded by IRH (90%) and ACCESS-FP (10%) and implemented by JHPIEGO/Burkina Faso and the MOH.

4.2 Strategy

Extensive advocacy preceded LAM introduction in Burkina Faso. Based on their previous experiences dating back to the 1990s, key decision makers from the Central

[6] National Institute of Statistics 2004
[7] Population Reference Bureau. 2004. *The Unfinished Agenda: Meeting the Need for Family Planning in Less Developed Countries*. Washington, D.C.: Population Reference Bureau.
[8] Demographic and Health Survey 2003

Directorate of Health in Ouagadougou perceived LAM as a short term method that would not be feasible to implement and that would not have much impact on contraceptive use. They were also skeptical about LAM's potential for success due to providers' bias against natural methods and the fact that each individual LAM user represents only 0.25 CYP. As such, it was important to present the new strategy of using LAM as an introduction to other methods. In meetings with MOH representatives, IRH presented how LAM would be positioned as an introductory method for postpartum women. While LAM was already included in the family planning standards, it had previously received little attention and was generally viewed as an "old" method. The credibility of JHPIEGO and IRH, along with the strength of the evidence presented, played an important role in these advocacy efforts, and the MOH agreed to pilot the approach.

The MOH suggested that LAM be first introduced in two districts of the central/Ouagadougou health region. The districts of Paul VI and Kosodo were chosen as most clinics there offer full services, including pre-natal, post-natal and maternity services. These two districts also had a community distribution network.

4.3 Implementation and Results

Policy/Advocacy:
The health system is decentralized in Burkina Faso, with 53 health districts and 13 autonomous Regional Health Directorates. Most LAM advocacy activities have been conducted through the Central District health department (Ouagadougou), where LAM has been piloted. At the national level, LAM had been incorporated into the MOH service protocols/guidelines. Officially LAM had also been integrated into the MOH management information system (MIS), but there was no coordination in the data collection process. IRH and JHPIEGO worked with the MOH to decide how to collect information on LAM use. The Central Health Department passed provisionary regulations and required all providers to record LAM users. Policymakers are regularly updated on progress and results of LAM activities. They now state that LAM will contribute to improvements in infant and maternal health programs and attract new family planning users. According to the Central Health Department Director, "LAM will help mothers understand that birth spacing is different than birth limiting". Policy makers now are strongly in favor of expanding LAM services to other areas of Burkina Faso.

Training:
Project activities started with IRH training JHPIEGO technical staff following the proposed approach and using the newly-developed tools. Contents of the training included the biological bases of LAM, how to use the method, client counseling, and issues likely to arise in provider training. As the JHPIEGO staff was going to manage the implementation process, including continuing advocacy, IEC activities, and supervision, emphasis was also put on programmatic issues related to motivating and supporting LAM users to make a timely transition to other family planning methods.

After this training, JHPIEGO and IRH co-trained 14 MOH trainers in a workshop organized and endorsed by the MOH. Trainees included 14 midwives from Kosodo and

Paul VI districts. A representative from the central government also attended the training.

Content of the training included basic topics such as LAM criteria, mechanism of action, effectiveness of LAM, advantages and disadvantages of LAM, the benefits of HTSP, and benefits of breastfeeding after LAM. Trainees were also taught to screen clients, how to counsel them to use LAM, and how to counsel and support women to make a timely transition to another family planning method. In addition to these core topics, emphasis was placed on LAM's potential as part of a strategy to reposition family planning overall and to bring non-users to family planning. Trainees worked on strategies to develop providers' skills to offer all family planning options and help women make a timely transition. The service delivery part of the training was based on the use of IRH-developed materials, including a manual, a resource notebook for participants, job aids and client materials. JHPIEGO later adapted some of these materials and translated them into local languages.

Provider training started soon after the training of trainers. Several providers from each selected facility were trained because staff rotates monthly among different positions within the facility. Trained providers helped train community health workers from their districts.

Table 1: Providers trained

	Midwifes	Auxiliary nurses	Community workers
District Kosodo	18	49	40
District Paul VI	23	61	60

Services:

LAM services were provided at nine sites by nurses, midwives, and auxiliary nurses. LAM was also offered by community distributors. Services were offered and promoted through antenatal clinics, child health clinics, well-baby visits, immunization visits, postpartum wards, during early labor, after delivery, and through community distribution. Women were presented with all available methods: informed choice was one of the guiding principles of the counseling. For clients choosing LAM, the initial counseling included instructions on how to maintain optimal breastfeeding practices and when to return to the provider (for breastfeeding support, for additional family planning). Clients were helped to choose another family planning method and to make plans to start using it as soon as they were no longer using LAM.

Providers reported an increase in family planning demand at their clinics after LAM was introduced. Many providers requested training on other natural methods of family planning as well.

Support Systems:

Supervision

JHPIEGO staff supplemented MOH supervision activities (which are not always carried out because of logistical or other reasons). During site visits, JHPIEGO staff assessed providers' technical competence using the Knowledge Improvement Tool (KIT), and

provided feedback and reinforcement to the initial training. IRH and JHPIEGO worked with the MOH to include LAM in supervision protocols and tools. Supervision visits also provided an opportunity to update providers and helped them document LAM users and plan for the clients' future contraceptive needs. Over 60 providers from Kosodo and Paul VI districts have been updated during site visits conducted by JHPIEGO staff.

Analysis of KIT data obtained during visits suggests that while providers were competently offering LAM, teaching women how to use it (including an emphasis on the benefits of exclusive breastfeeding) and when to return for additional family planning, few providers discussed fertility intentions with their clients. Messages on HTSP were also absent from most counseling sessions.

Providers reported that progestin-only pills and injectables were the methods most commonly used after LAM. There was some information in the clinic registers to back these observations, but providers did not accurately or consistently register information on services provided to clients, so it was not possible to estimate the percentage of LAM users adopting other methods.

Providers' reports confirmed anecdotal information regarding cultural and practical obstacles for exclusive breastfeeding in Burkina Faso. The most common was the practice of giving infants pre-lacteal feeds including extra water, herbs and teas by mothers-in-law. Several women who attended the clinic said that they could not use LAM because their mothers-in-law insisted on feeding the baby. This issue could be addressed during counseling or through BCC activities targeting other audiences. MOH policy-makers are now aware of the implications of these alternative feeding practices.

Management Information System

LAM has long been part of the Burkina reproductive health policy and norms but had not been included in the MIS procedures and tools. It did not appear on the client recording form, which is the staring point for service statistics. As an alternative solution, the MOH proposed that LAM be recorded under "other" in the form. Providers were instructed to annotate LAM clients under "other methods" in clinic registries and in monthly reports. However, given the possibility that information on LAM users recorded in such manner would get lost as service statistics moved up in the system, JHPIEGO staff collected data on LAM users during their monthly supervision visits. Information collected includes the number of LAM users, number of first-time family planning users, and number of users of other methods at the clinic. This information was consolidated into a report shared with the MOH. JHPIEGO is working with the MOH to include LAM when MIS forms are updated.

Behavior Change Communication (BCC)

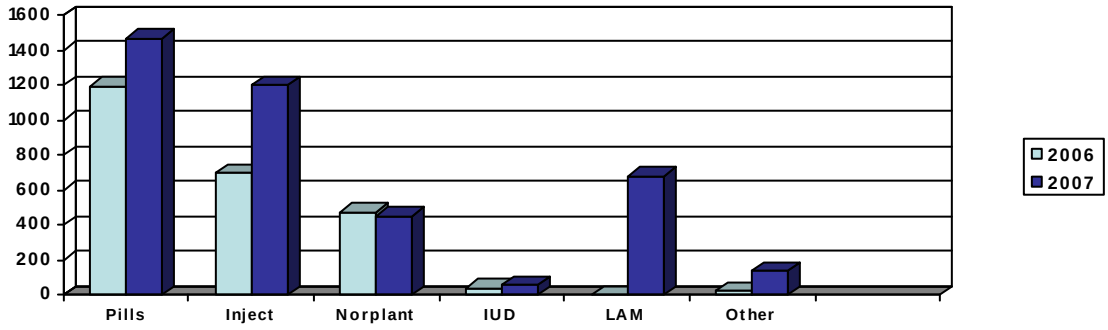
LAM messages were mostly disseminated through family planning workers, generally midwives, who gave information on LAM to clients in waiting rooms. They also promoted the method while visiting community organizations, such as mothers' clubs, religious groups, and women's organizations. Community members attended street drama presentations where LAM messages were conveyed. These meetings played a unique and important role in dissemination of information, as they provided an opportunity for participants' questions and concerns to be addressed quickly. A

message that stresses the contraceptive benefits of breastfeeding was developed and printed on T-shirts and calendars that were distributed to all participating clinics. In collaboration with the MOH, JHPIEGO disseminated LAM messages through talk shows and information sessions related to health on national radio. A television spot encouraging men to support their breastfeeding wives was developed. The spot - in French and Mooré - was aired during a two month period.

Clients:
LAM clients were mostly recruited through prenatal and maternity services. Family planning messages in general, and LAM in particular, were given to women in the waiting and delivery rooms. Of over 1000 women who received information in these places, more than 350 chose LAM and received counseling on how to use the method. They were followed monthly to see if and when they start using another family planning method. Over 300 women who received information on LAM through community outreach activities or by word-of-mouth also adopted the method.

After seven months of implementation, service statistics from the nine project sites indicated not only a total of 681 women choosing LAM but also important increases in numbers of users of most other modern methods. Overall, the number of users of modern methods increased by 61% from 2,432 new clients in 2006 to 3,988 new clients in 2007. The exception was Norplant which saw a small reduction in users; a three-month stockout of implants in 2007 contributed to this decline.

Figure 1: New clients by method in Burkina Faso intervention sites, 2006 and 2007



4.4 Discussion and next steps

Although initially providers and policymakers felt that there was no need to spend time on a method that "will only last for six months", they now acknowledge that the availability of LAM services offered in the context of HTSP, informed choice, and with an emphasis on supporting women to make a timely transition to other family planning methods is showing an impact on use in the communities served by the nine facilities where the intervention is being piloted.

Providers and decision makers, having overcome their initial skepticism about re-introducing LAM in MOH services, are now interested in continuing to offer the services and expanding them to other areas of the country. The issue at this point is one of

resources to support this expansion, including strengthening some support systems such as training, supervision and MIS to ensure quality services.

5. LAM PROJECT IN MALI

5.1 Background

The overall goal of the LAM pilot project in Mali was to determine the feasibility of implementing IRH's approach to LAM as a bridge to other family planning methods in MOH services, thus increasing access to and use of effective family planning methods by postpartum women.

Geographically the largest country in West Africa, Mali has approximately 12 million inhabitants, roughly 70 living in rural areas. Close to 90% of Malians are Muslim, and the practice of polygamy is extensive, accounting for 43% of married women. The most recent demographic and health survey estimates the maternal mortality ratio in Mali at 557/100,000 live births. The major causes of maternal mortality include hemorrhage, unsafe abortion, sepsis, and obstructed labor[9].

Family planning use is very low in Mali. Less than 9% of women in union use a method of contraception, with modern methods accounting for approximately two thirds of total prevalence[10]. According to a 2005 MOH report, most children aged 0-5 months have been breastfed. A few organizations have incorporated LAM into their child survival or nutrition programs, but the MOH has no report of the impact of these services. Most service delivery personnel are aware that breastfeeding extends a woman's period of postpartum infertility[11]. However, they do not convey this knowledge to their clients. Women have a positive view of breastfeeding, perceiving it as an inexpensive, nutritious way of feeding their children.

Although LAM is included in the national norms and is one of the methods officially available from MOH providers, it is rarely offered. Reasons for this include lack of trained personnel and lack of awareness on the part of providers and managers of LAM's potential.

After initial advocacy activities to explain the proposed approach to LAM, MOH officials welcomed the opportunity to revitalize LAM services within the MOH as a way to help postpartum women adopt reliable family planning methods and thus better space their pregnancies, and also as a tool to improve breastfeeding practices and child nutrition. In discussions which included the MOH, the USAID Mission and IRH, it was decided to start LAM reintroduction with a pilot project in one area of the country.

5.2 Strategy

The Mali national health structure operates at five levels of service delivery: 1) referral hospital which provides health services in Bamako; 2) regional hospitals located in each

[9] DHS Mali 2001
[10] 2005 Population Data Sheet, PRB
[11] publications/mothers/2007/SOWM-2007

regional capital, 3) CSRefs (reference health centers) which operate at a district, or "cercle," level; 4) CSComs (community health centers) which provide services at the village/community level and 5) community distribution channels.

The MOH, IRH and the mission chose to integrate LAM as a pilot project in one region, with the MOH as the implementing partner, in order to closely monitor services and conduct research, with the understanding that results of the pilot project would guide decisions regarding expansion of LAM services to a national scale over time. The Koulikoro region (population 1.8 million, contraceptive prevalence 2%) was selected for logistical reasons. Koulikoro is divided into nine districts (Cercles) encompassing 140 CSComs, of which 120 are full clinics with pre-natal, maternity, and post-natal care. The Koulikoro Regional Health Department was the project's implementing partner. LAM was introduced to approximately 120 health centers throughout the nine districts of the region.

5.3 Implementation and Results

Policy/Advocacy

The MOH has included LAM in their reproductive health policy and norms. High level policy makers have publicly expressed their support for the approach of repositioning LAM as a bridge to introduce post-partum women to other family planning methods. The MOH has agreed to include LAM in the upcoming client register card, as an effort to fully integrate LAM into the national MIS.

Training

Two training-of-trainers (TOT) workshops were conducted by IRH in December 2006, for 35 trainers, three regional supervisors, and four participants from the central MOH who are also considered national supervisors. Technical topics included how LAM functions, its physiology, advantages of the method, how to counsel clients on LAM, how to train providers, and other methods appropriate for breastfeeding mothers. The programmatic content of the workshop included LAM's role within HTSP strategies, emphasizing how to support the transition to other family planning methods in program planning, training of providers and client counseling.

Provider training was initially planned for early 2007. At the request of the MOH and in agreement with USAID, LAM training for providers was postponed, for logistical and budgetary reasons, and in order to not overburden central level MOH and local IRH staff who were fully engaged in training providers in the SDM (which was being widely introduced in Mali) and providing other technical support, to ensure SDM services started as scheduled and in an orderly manner.

IRH staff trained 16 regional trainers from Koulikoro. Before starting provider training in June 2007, IRH staff worked with trainers to reinforce their knowledge of LAM and plan for provider training activities. This work was supported by nine regional trainers who had participated in the initial TOT workshop and traveled with Koulikoro regional trainers to the districts to train providers. IRH staff accompanied and supported them for the first round, in the district of Kati, and provided feedback to trainers. Just as in initial stages of the training cascade, training of providers focused on the basics of how to use LAM and

how to support women to adopt other family planning methods in a timely manner. Another area of emphasis was timing when different methods can be started by postpartum women. Providers were also instructed on how to record LAM users. During the period of June to December 2007, providers from all nine districts, including Dioila, Fana, Banamba, Kangaba, Narha, Kati, Kolokani, and Koulikoro were trained to offer LAM. At least two providers, mostly midwives and auxiliary nurses (matrons) from each full CSCom were trained.

Table 2: LAM Trained Personnel

Province	Sites with Trained Providers		Total # of trained personnel	
	CSRef	CSCOM	Trainers	Providers
Koulikoro	7	146	25	284

For logistical and budgetary reasons, the MOH is conducting LAM and SDM training for providers on consecutive days in some provinces. IRH and the Population Council are taking advantage of this situation and conducting a natural experiment, to assessing the effectiveness and feasibility of two different training strategies: 1) interval: training providers first on LAM, and then on the SDM three months later (as is scheduled to occur in some sites); and 2) back-to-back: training providers on the SDM and LAM over two consecutive days (which will occur in other places). Indicators include provider knowledge and performance as assessed with the use of the KIT, cost-effectiveness, and method integration[12].

IRH is collaborating with IntraHealth and the MOH to include LAM in pre-service education of health professionals.

Services

LAM is being offered in the context of HTSP and as one of several options available for postpartum women. It is being offered through prenatal, peri-natal and post-natal client-provider contacts. IRH staff has been able to confirm during site visits that LAM counseling includes not only instructions on how to maintain exclusive breastfeeding and information on when to return to the provider, but also emphasizes the importance of moving to another modern method. Site visits also have confirmed that providers support clients to start selecting their next method as soon as they start using LAM. When available, they provided commodities for clients to begin using another method without needing to come to the clinic. Clients are encouraged to return to the clinic as soon as any LAM criterion changes, at any time if they want to change to another family planning method, or if they have any breastfeeding difficulties.

Service Delivery Support Systems

Supervision

In Koulikoro, MOH regional trainers also serve as supervisors. IRH trained supervisors in the use of KIT to correct shortcomings during supervision visits. Supervisors plan to use it during their site visits. They will also monitor clinics for accurate data collection. IRH field staff will conduct regular review meetings with regional supervisors and

[12] Study protocol is available from IRH.

analyze service delivery issues. At the time of this report, supervision visits by the MOH had not started in Koulikoro.

Management Information System
LAM has not yet been included in MIS forms. Providers were instructed to annotate LAM users under "other method" in the daily clinic registries and in their monthly reports. Since LAM services are just starting, and it takes time for the information to move upwards in the system and be consolidated, service statistics have not been reported to the regional level. However, clinics' logbooks suggest that many post-partum women are receiving LAM counseling and are adopting the method. For project monitoring purposes IRH staff collects data at the CSRef level. IRH continues to work with the regional health directorate in Koulikoro (DRS-Koulikoro) on how best to collect valid service statistics.

IRH distributed client and provider tools, and held discussions with the DRS-Koulikoro on possible awareness-raising activities targeted at different audiences.

Behavior Change Communication (BCC)
IRH is collaborating with ongoing family planning and maternal child health programs to promote HTSP, LAM and the timely use of other family planning methods appropriate for breastfeeding mothers. HTSP messages were highlighted in all LAM promotional activities. A poster promoting LAM and other family planning methods was developed by IRH and is being pre-tested in Mali. Other opportunities such as health shows and talks were also used to promote LAM.

5.4 Discussion and Next Steps

The LAM program is still in its beginning stage in Mali. While preliminary information suggests it is having an impact in terms of women using the method, this needs to be verified through service statistics. The MOH and USAID are supportive of the expansion of LAM services to other areas of the country. IRH will continue supporting regional trainers to train more providers and community health workers, in order to assure an acceptable level of quality. IRH will also continue to provide technical assistance to the DRS-Koulikoro to address systems issues including:

- Supervision (support supervisors to carry out site visits, and support their use of the KIT).
- Service statistics/MIS (ensure that LAM users are recorded appropriately and the information is incorporated into overall MOH data).
- IEC strategies and activities, focusing on key audiences including potential method users, men, extended family/community members, and religious leaders.
- Monitoring introduction activities; documenting training, IEC, organizational support; and service delivery.
- Small-scale follow-up of trained providers to assess knowledge, attitudes, and skills in service delivery.
- Identifying sites for scaling up (to be carried out in the integration phase).

6. MAIN CHALLENGES REMAINING IN BURKINA FASO AND MALI

When using LAM as her family planning method, the woman is encouraged to breastfeed exclusively. However, in Burkina Faso and Mali, grandmothers and other family members give water to very young children as a traditional blessing. Sometimes they give water in large quantities and/or add other foods at an early age.

Supervision systems need strengthening overall. Personnel tasked with supervision activities also have other duties, and supervision is not seen as the priority. IRH is working with supervisors to strengthen their LAM knowledge and skills. Results of this support may be seen when MOH personnel carries out site visits.

Data collection has proven to be problematic. LAM is included in the national norms/policy and officially is already in the MIS. However data collection is not accurate or systematic. Data is collected from the client card and clinic register, and then sent to the reference hospital where it is coded, computerized and sent to the national level. At the clinic level, LAM users are registered in the “other” column. At the reference hospital level, there is no code for LAM yet. This can cause information on LAM users to be lost at the transition point from handwritten records to computerized information. IRH has shared experiences from other countries with the MOH and continues to work with them to include LAM into the MIS.

7. CONCLUSION

After nine months of implementation in Burkina Faso, service statistics show moderately large numbers of LAM users, and moderate increases is users of other methods at the sites now offering LAM. Preliminary information suggests a similar situation is beginning to occur in Mali.

Observations by IRH staff during site visits suggest that training activities and follow-up are leading to the appropriate levels of provider technical competence to LAM.

There are many opportunities for scaling up LAM services in Burkina Faso and Mali. Commitment to family planning in general on the part of program managers and providers, and their current recognition that LAM can play an important role has been an important factor in the high acceptance of LAM by clients at participating clinics.

The MOH, program managers, health facility staff, and clients are supportive of the method and there appear to be significant opportunities for research on the impact of LAM on HTSP, contraceptive prevalence, and support for family planning by a variety of stakeholders. More remains to be done in terms of documenting the transition from LAM to other modern methods, and in overcoming barriers to women’s use of LAM and supporting exclusive breastfeeding. More information needs to be systematically collected to document LAM users’ transition to modern methods. Because of support from the MOH and the facilities for the method, the existing sites provide a opportunity to follow a sample of users over time to document their transition to other modern methods and answer key research questions.

Teaching Women to use LAM

Q: Who can use LAM? A: *A post-partum woman who meets all three of these conditions.*

1. The baby is breastfed at least every 4 hours day and night and not given any other food, water or liquids.
2. The mother's menstrual bleeding has not returned.
3. The baby is less than 6 months old.

Teach the mother how to use LAM:

- Breastfeed as often as your baby wants, day and night.
- Breastfeed your baby at least every 4 hours.
- Continue to breastfeed even when you or your baby is sick.

- Do not give your baby any foods, water, or other liquids before 6 months of age.
- Breast milk gives your baby everything she/he needs to be healthy.
- Do not use bottles, pacifiers or other artificial nipples. These discourage your baby from breastfeeding as frequently.

- You can use LAM until your baby is 6 months old or is receiving any foods or liquids, or your menstrual bleeding has returned.

Why are the three conditions important?

1. **When the baby receives any food, water or other liquids:**
   - The baby becomes full and will not want to breastfeed as often.
   - The mother will not produce as much breast milk.
   - Infrequent suckling of the breast will make the mother's fertility return. She can get pregnant.
2. **When the mother begins her menstrual bleeding she is fertile again. She can get pregnant.**
   (Any bleeding after the baby is two months old is considered menstruation.)
3. **When the baby turns 6 months old the mother's fertility will return. She can get pregnant.**

Tell the mother that she should not get pregnant again until her baby is at least two years old.
Give the mother information about methods she can use after LAM.
Tell her to think about these methods and choose one so she is ready to use it when LAM no longer works for her.

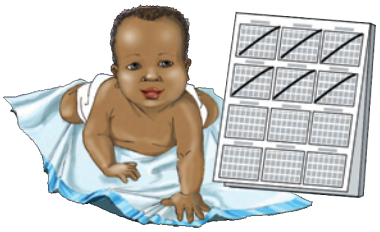
Help women choose another method:

These women are fertile again and need to start using another family planning method:

A mother whose baby receives other foods or liquids (even if the baby is still breastfeeding).

A mother who has begun her menstrual bleeding.

(Any bleeding after the baby is two months old is considered menstruation.)



A mother whose baby is 6 months or older.

Counsel the woman who cannot use LAM:

1. Tell the mother that LAM will not protect her from pregnancy.
2. Encourage her to continue breastfeeding her baby.
3. She must start using another method now:

Other methods:

All Women	Breastfeeding Women	Non-Breastfeeding Women
• Condoms • Intrauterine Devices • Natural Family Planning Methods** • Diaphragm/cervical cap • Vasectomy • Tubal Ligation**	• Progestin only methods (pill, injectables, implants) • Combined estrogen-progestin (pill, injectables)	• Progestin only methods (pill, injectables, implants) • Combined estrogen-progestin (pill, injectables)

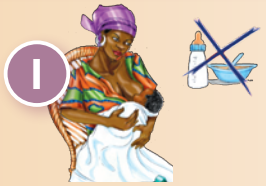
** If the specific criteria are met.

Tell the mother that she should not get pregnant again until her baby is at least two years old.

LAM

A Family Planning Method for Breastfeeding Women

LAM prevents pregnancy if all THREE conditions are met:

1. 
   You only breastfeed your baby

2. 
   Your menstrual bleeding has not returned since your baby was born

3. 
   Your baby is less than 6 months old

If you do not meet all THREE conditions, begin using another method immediately.

Spacing pregnancies is important for the health of mother and child. After giving birth, wait two years before getting pregnant again.

LAM

A Family Planning Method for Breastfeeding Women

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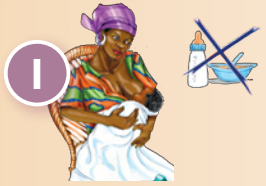
1. 
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   Your baby is less than 6 months old

If you do not meet all THREE conditions, begin using another method immediately.

Spacing pregnancies is important for the health of mother and child. After giving birth, wait two years before getting pregnant again.

DRAFT

Breastfeeding will give your baby all the food and liquid necessary to grow and be healthy until he/she is 6 months old.

While Using LAM:

Breastfeed as often as your baby wants, day and night.

Do not give your baby other foods or liquids before the age of 6 months.

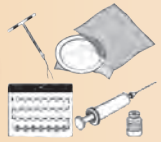
Continue to breastfeed even when you or your baby is sick.

Begin thinking about a new method.
Be ready to use another method when LAM no longer protects you from pregnancy.

When you no longer meet all three conditions:

1. 

   Contact your provider and begin using another method immediately.

2. 

   Other methods you could use are: condoms, certain pills, certain injections, IUDs, natural methods, vasectomy and tubal ligation.

3. 

   Continue to breastfeed your baby.

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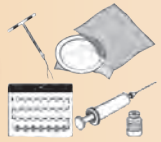
2. 

Other methods you could use are: condoms, certain pills, certain injections, IUDs, natural methods, vasectomy and tubal ligation.

3. 

Continue to breastfeed your baby.