LAM and the Transition Barrier Analysis: Uganda and Guinea

Dr Robin Anthony Kouyaté
Dr Winifride Mwebesa

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For more information about ACCESS-FP, please visit www.accesstohealth.org/about/assoc_fp.html.

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EXECUTIVE SUMMARY

Background
The lactational amenorrhea method, or LAM, is a modern, reliable family planning (FP) method—shown to be at least 98% effective in clinical trials. LAM can protect a woman from pregnancy as long as she meets the following three criteria: 1) she is fully or nearly fully breastfeeding; 2) she is in postpartum amenorrhea; and 3) she is less than six months postpartum. If any one of these criteria changes, the woman is no longer protected against pregnancy and she needs to transition to another FP modern method.

With regard to transition, current research indicates that: between 48% and 86% of LAM users transition to another modern method; LAM users are more likely to transition to a modern method by 12 months postpartum than women who use breastfeeding for FP without knowing LAM criteria and women who use traditional methods; and delays in transition are often attributed to waiting for menses to return. A recent study in Bangladesh explored the facilitators and barriers to the transition from LAM to other modern FP methods and has been reported elsewhere.¹ Not much is known about these factors in Africa.

The purpose of the study was to gain better understanding of the facilitators and barriers to the transition from LAM to other modern FP methods in two African countries: Guinea and Uganda. In each country, the study was nested with Save the Children’s Family Planning Program and conducted by the program team with support from ACCESS-FP and Save the Children’s FP technical advisor.

Methods
In each country, 40 transitioners and 40 non-transitioners* who had used LAM for at least three months and transitioned no earlier than three months postpartum were interviewed. Participants in both Guinea and Uganda were stratified by parity (high versus low). In Guinea, it was also captured whether participants were in monogamous or polygamous relationships. In addition, husbands and mothers-in-law of 10 transitioners and 10 non-transitioners were also interviewed to triangulate data on social support.

Data collection was done using a mixed method design: in-depth interviews to document the decision making process around LAM and the transition to other methods, and barrier analysis semi-structured questionnaires were used to identify the key differences between transitioners and non-transitioners in specific behavioral determinants.


* In Uganda the sample contained 42 transitioners and 39 non-transitioners
Results

Knowledge: Women in Uganda were more likely to recall all three criteria compared to their counterparts in Guinea. Regardless of transition status, the criterion most often forgotten in Uganda was “no menses” while in Guinea, “baby less than six months” was most often forgotten. However, when asked what they had learned about switching from LAM to another method; women in Guinea provided a range of answers that demonstrated they had understood why it was important to transition by providing the benefits of LAM transition (space pregnancies or prevent unwanted pregnancies); return to fertility and change in criterion but were not clear about the timing of transition.

Decision-Making Process: Among the 40 transitioners interviewed in Guinea, four (10%) women transitioned before LAM criteria changed (early transitioners); 20 (50%) women transitioned as soon as LAM criteria changed (timely transitioners), while the remaining 16 (40%) LAM users transitioned at least one month after LAM criteria changed (delayed transitioners). Eight (50%) of the 16 delayed transitioners waited one month after the first criterion changed to switch to another modern method. The remaining eight (50%) waited two months or more. Among all transitioners, 21 (52.5%) switched to another method before their menses returned.

Transition: During in-depth interviews, 20 LAM transitioners in each country were asked which methods they had transitioned to. Most LAM transitioners in Guinea reported switching to combined oral contraceptives followed by injectables. In Uganda, most LAM transitioners switched to injectables (which in these districts are available through community reproductive health workers - CRHW) followed by combined oral contraceptives and some implants. A substantial proportion of women in both countries obtained the methods themselves; from CRHWs in Uganda (70%) and health centers in Guinea (65%). LAM transitioners in Uganda provided the following motivators for transitioning: ability to work or take care of family; being able to provide for family; children’s health; having time to rest and previous experience with closely spaced pregnancies.

Barriers:
In Uganda, during in-depth interviews, the majority of the 20 non-transitioners reported both their desire to space (n=16) and limit future pregnancies (n=4). Participants indicated ten reasons for not transitioning: waiting for menses (n=6), difficulty with availability of methods (n=2), belief that breastfeeding protects from pregnancy (n=2), menses had just returned the day before or day of (n=2), misconceptions about methods (n=1), lack of support from husband (n=1), husband away (n=1), concern about side effects (n=1), unexpectedly giving cow’s milk for two days when baby was sick, and misunderstanding of the LAM criteria (n=1). In addition, non-transitioners in Uganda were more likely to: 1) perceive the severity of closely spaced births 7-12 months postpartum or 2) perceive side effects as a disadvantage of transitioning.

In Guinea, during in-depth interviews, participants indicated seven reasons for not transitioning: lack information on other modern methods (n=4), availability of methods (n=5), waiting for menses/fertility pattern (n=4), sexually inactivity due to marital difficulties (n=3), fear of informing spouse (n=2), financial constraints (n=1), and concerns about sterility (n=1). Non-
transitioners in Guinea were more likely to: 1) believe that they were only at risk for pregnancy 1 year or more after a delivery, if not using LAM or another FP method and 2) report that their husbands made the transition difficult.

Conclusions
The research in both Uganda and Guinea highlights that women often wait for menses to return or strongly rely on personal fertility patterns as determinants about when to switch to another method.

The return of menses remains an important cue to transition similar to the Bangladesh study. In Guinea, it was the cue most frequently mentioned by both timely transitioners and delayed transitioners. In Uganda, in-depth interviews with non-transitioners identified waiting for menses as the main reason for not switching.

The social context in both settings also influences the decision to transition. This study revealed varying sources of social support, dynamics related decision-making with husbands, including the influence of polygamy. The husband could be an important source of social support and encouragement; while older co-wives in Guinea could also support LAM transition. Most women in both countries obtained the transition FP method themselves; very different from the Bangladesh study where women had restricted mobility and relied on their husband or mother-in-law.

It is also notable that changing norms in Guinea are resulting in earlier resumption of postpartum sexual activity. In Uganda, pressure from the husband or concerns about infidelity led to reported resumption of sexual activity by two to three months postpartum.

Recommendations
Changes need to be made to programs to ensure the issues identified in the study are addressed in order to improve transition from LAM to other modern methods. Messaging should clarify and further emphasize the risk of pregnancy prior to the resumption of menses, the limitations of breastfeeding alone in preventing pregnancy and the fact that previous birth to pregnancy intervals are predictive of future pregnancy timing.

Counseling should be improved to ensure better understanding of side effects and expanding the method mix particularly in Guinea.

Interventions should take into account shifting norms in the resumption of sexual activity during the postpartum period and ensure that women have the information and methods they need early enough to transition in a timely manner.

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To ensure better social support, there is a need to engage men in both countries, involve mothers in law (Uganda) or co-wives (Guinea). In addition, interventions should include other sources of social support, such as friends (Uganda and Guinea) and other relatives (Guinea).
BACKGROUND

The Lactational Amenorrhea Method (LAM)
The lactational amenorrhea method, or LAM, is a modern, reliable family planning (FP) method—shown to be at least 98% effective in clinical trials.\textsuperscript{3,4} LAM can protect a woman from pregnancy as long as she meets the following three criteria:

- She is fully or nearly fully breastfeeding
- She is in postpartum amenorrhea
- She is less than six months postpartum

Women who choose LAM are encouraged to exclusively breastfeed their child through six months and to introduce complementary foods at six months and to continue breastfeeding for 24 months. When women no longer meet any of the above criteria, they are asked to return to a provider and to immediately start using another FP method.

LAM As a Gateway Method
An Interagency LAM Working Group comprised of LAM program managers and implementers identified the importance of repositioning LAM as a gateway method to other modern FP methods. As such, the timely transition from LAM to other modern methods is encouraged and emphasized. Ideally, when a LAM user’s fertility returns, she will have already chosen her next method, increasing the likelihood that she will begin using it promptly.

This proposed LAM transitional approach supports women’s reproductive intentions and functions in a context of informed choice. Postpartum women are offered all appropriate FP methods; those who choose LAM receive counseling that covers the specifics of using LAM, as well as healthy spacing of pregnancies, returning to fertility and determining which method to use after LAM. Follow-up visits also include discussion of the FP method that the woman will transition to after completing LAM.\textsuperscript{5}

What is Known About LAM Transition
Research has improved and expanded our knowledge about the effectiveness of LAM,\textsuperscript{6} our comprehension of the characteristics of LAM users\textsuperscript{7} and our understanding of the factors that

\textsuperscript{5} LAM Interagency Working Group. Repositioning the Lactational Amenorrhea Method: Benefits for Women, Children and Programs. \url{http://www.ppftoolkit.org/LAM/LAM.html}.
\textsuperscript{7} Bongiovanni A et al. (2005). Promoting the Lactational Amenorrhea Method (LAM) in Jordan Increases Modern Contraceptive Use in the Extended Postpartum Period. The LINKAGES Project. Academy for Educational Development.
influence LAM use.\textsuperscript{8} With regard to transition, current research indicates that between 48% and 86% of LAM users transition to another modern method.\textsuperscript{9} Research also indicates that LAM users are more likely to transition to a modern method by 12 months postpartum than women who use breastfeeding for FP without knowing LAM criteria and women who use traditional methods.\textsuperscript{10} Delays in transition are often attributed to waiting for menses to return.\textsuperscript{11} A recent study in Bangladesh explored the facilitators and barriers to transitioning from LAM to other modern FP methods.\textsuperscript{12} However, less is known about these factors in Africa.

\textbf{LAM Transition in Guinea and Uganda}

In both Guinea and Uganda, understanding the barriers to transitioning from LAM to other modern FP methods offers an important opportunity for improving the health of mothers and newborns by improving pregnancy spacing and reducing the risk of unplanned pregnancies during the first year postpartum. According to the latest Demographic Health Surveys (DHS) conducted in both countries, (Guinea 2005 and Uganda 2006), use of family planning is relatively low with respectively seven percent of women in Guinea and 18% of women in Uganda using a modern FP method. Both countries are marked by high child mortality rates (163 deaths/1000 live births for Guinea and 138 deaths/1000 live births for Uganda.)

The DHS surveys also showed that most women deliver at home; 69% in Guinea and 58% in Uganda, and very few women actually access postpartum care. In Guinea, only 13% of women accessed care within two days after delivery. In Uganda, only 23.6% of mothers had received any postpartum care within the first 41 days. Most mothers are discharged between 6-24 hours after delivery and encouraged to come back after six weeks to bring the baby for immunization. Limited information regarding family planning is provided to these mothers at any point.

In Uganda, 25.2% of births occur within short intervals of less than 24 months. In Guinea, 11.5% of births occur within the same timeframe. Breastfeeding patterns indicate a median duration of exclusive breastfeeding of 3.1 months and 0.6 months respectively for Uganda and Guinea. In addition to limited practicing of exclusive breastfeeding, women in both Uganda and Guinea also experience short postpartum abstinence which sets them at risk for short birth intervals.

To better address these factors in both countries, ACCESS-FP through its partner Save the Children replicated the study that had been conducted in Sylhet, Bangladesh.

\textsuperscript{10} Bongiovanni A et al. (2005).
\textsuperscript{11} Bongiovanni A et al. (2005); Khan et al. (2008).
\textsuperscript{12} Anthony Kouyate R. (2010).
In Guinea, Save the Children has been implementing child survival health programs in Upper Guinea since 1998 and in 2002, in collaboration with CHANGE, Save the Children conducted a survey on the practices and use of health services during the early post-partum period in the Mandiana district. Results from the qualitative research were used to develop early post-partum visits for recently delivered mothers and newborns by community health workers.

In 2003, Save the Children secured funding from USAID Flexible Fund, to add FP activities to the USAID funded Child Survival 18 project, reaching a population of 118,002 women of reproductive age in two health districts (Mandiana and Kouroussa) of the Kankan Region in Upper Guinea. The program was implemented with the different levels of the Ministry of Health (district and central region) and in partnership with two local NGOs (AJVDM of Mandiana and GAAPE of Kouroussa) to support community based services. As a result, 450 community workers in 225 villages were trained in the distribution of contraceptive methods (condoms and oral contraceptives) and counseling mothers who have recently given birth about LAM and making referrals for clinic-based methods (Depo Provera (Depo), IUDs and longer acting and permanent methods). Half of these community workers are women and about 10% of them are village midwives trained in EmOC. At the village level, the CBD agents operate within a structure called the Village Health Committee (VHC). The VHC oversees Behavior Change Communication activities at the village level and mobilizes women and their families to access family planning, immunization, nutrition, maternal and newborn health services including EmONC and STD / HIV / AIDS services. Save the Children also supports clinic based services by training health workers in counseling, contraceptive technology and monitoring and supervision of CBD agents.

In Uganda, Save the Children has been implementing a USAID funded four-year, three-district Family Planning Program since 2005. The program is targeting an estimated 170 women and 285 men of reproductive age in three central Uganda districts: Nakasongola, Nakaseke and Luwero. Save the Children works with district and local level MOH structures to provide access to family planning information and services through a network of over 120 community-based reproductive health workers (CRHWs) and health facilities (Health Center (HC) IIIIs and district hospitals). CRHWs provide FP related information and distribute select contraceptive methods such as pills and condoms; counsel recently delivered mothers about LAM and make referrals to HCs for longer acting and permanent methods. Save the Children has also trained select CRHWs to provide injectable contraception. Additional family planning services are available at health centers where providers have received training in improved counseling, contraceptive technology and contraceptive logistics management. HCs also provide maternal and child care services including antenatal care, delivery, postnatal care and immunization services. In the same districts, SC implemented a MNCH program (HAPI) that targeted mothers of children under five with a focus on improving maternal and newborn health by strengthening prenatal care. Under this program, the same CRHWs who were trained to provide FP information and

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13 CHANGE: a five-year (1998 – 2003) USAID-funded global project led by AED and designed to identify, develop and apply innovative behavior change tools and approaches to improve behaviors relevant to maternal health, child health and nutrition.
services provided household counseling to pregnant women, encouraged women to attend ANC and distributed mama kits (clean birth kits). In addition, they have been providing immediate postnatal/postpartum visits where birth spacing is discussed and LAM use promoted.

**Postpartum Family Planning and LAM Intervention**
In 2009, Save the Children received funding through ACCESS-FP to strengthen postpartum family planning services in both Uganda and Guinea. While LAM had already been introduced as a method, little was known about transition rates or the factors that influence the decision to transition to another modern method once criteria for LAM are no longer met.
METHODS

Study Design
In both countries, the study was carried out through the existing Save the Children Family Planning Programs. In Uganda, participants were selected from all three districts in Central Uganda while in Guinea, they were recruited from 6 sub-prefectures in the district of Mandiana. Sub-prefectures in Guinea were selected based on level of FP use. In order to ensure that the full range of facilitators and barriers was captured, the following criteria were used to select sites: distance to main town, distance to Office (accessibility), geographic location, ethnic group, socio-economic activities, and religion. In addition, the number of health units, (i.e. access to formal health systems) as well as the number of community health workers was identified for each site. The community health workers were also instrumental in facilitating identification of respondents and following up with respondents. (Annex 1)

Participants who had used LAM were interviewed in order to explore the barriers to the LAM transition and the factors that influence LAM users’ decisions to transition to other methods or not. A mixed-method design was used for data collection, including in-depth interviews and semi-structured questionnaires. Fourteen in-depth interview questions were used to document the decision-making process around LAM use and the transition to other modern methods. Data from the semi-structured interviews was collected using the Barrier Analysis design and were used to identify key differences between “transitioners” and “non-transitioners”. Derived primarily from the theoretical underpinnings of the Health Belief Model and the Theory of Reasoned Action, Barrier Analysis methodology guides participants through a series of questions to identify eight potential determinants (most of which are “barriers”) that can prevent people from taking action. It also helps to identify the positive attributes of a behavior that can be used to help encourage or reinforce desired behaviors during health promotion or other educational efforts. Specific behavioral determinants of the transition from LAM to other methods were identified and include the following:

- Perceived susceptibility to pregnancy
- Perceived severity of closely spaced births
- Perceived efficacy of timely transition for spacing/prevention of unintended pregnancy
- Perceived social acceptability of the transition
- Perceived self-efficacy (LAM use and the transition)
- Cues to transition
- Perception of divine will
- Positive attributes of the transition
- Negative attributes of the transition

Eligibility to Participate in the Study
In both countries, a purposive sample of “transitioners” and “non-transitioners” was selected from a group of LAM users identified in each program. For the purposes of this study, a LAM user is defined as a woman who had used LAM for at least three months postpartum, and who could: name the method of LAM, remember at least two LAM criteria and report using LAM. A LAM “transitioner” is defined as a woman who had switched to another method when one of the three criteria changed and no earlier than three months postpartum. Non-transitioners are defined as women who did not switch to another modern method after LAM, and include women who had switched to traditional methods. Non-LAM users are defined as women who did not use LAM or used LAM for less than three months postpartum, and were not eligible to participate in the study.

Sample Size and Sampling Strategy:
The goal was to reach a total of 40 transitioners and 40 non-transitioners in each country. Participants in both Guinea and Uganda were stratified by parity (high versus low). High parity was operationally defined as having 3 or more living children, and low parity was defined as two or less. In Guinea, participants were also stratified by the status of their marriage: monogamous or polygamous relationships, as previous program feedback indicates that issues may differ for these two groups. In addition, husbands and mothers-in-law of 10 transitioners (5 high parity, 5 low parity) and 10 non-transitioners (5 high parity, 5 low parity) were also interviewed to triangulate data on social support. Whenever possible, husbands and mothers-in-law of the same postpartum woman were interviewed for complete triangulation of data.

Figure 1: Sampling for LAM Transition Study
All respondents completed semi-structured barrier analysis questionnaires. Boxes in green represent subsets of the sample (women, husbands and MILs) who participated in in-depth interviews.

**Data Collection**

Instruments used in Bangladesh were adapted for each country and translated into Luganda for Uganda and into French and Maninkan for Guinea.

In Guinea, a pre-test was conducted in two villages located 7-8 km from Kankan and outside the intervention area. Interviews were conducted with mothers of children under the age of one and a few husbands. Unfortunately, no women fulfilled the eligibility criteria for LAM use, none were aware of LAM and most women reported reliance on abstinence to space children till the age of two. As a result, the pre-test had to be repeated within Save the Children’s program area but in villages that had not been selected for the research. Overall data collected lasted one month and was conducted by the team (Health Coordinator, two midwives with experience in qualitative data and two field staff). Data entry was performed by the program Monitoring and Evaluation Advisor.

In Uganda, following an orientation to barrier analysis, program staff composed of the Monitoring and Evaluation Officer, two district officers and two health extension workers dedicated approximately seven months to collecting data. Data entry was conducted by an external consultant.
DATA ANALYSIS

Comparison of Transitioners and Non-transitioners
Sample sizes were small and not designed to detect a difference between LAM transitioners and non-transitioners on related variables. However, mean values are reported for transitioners’ and non-transitioners’ socio-demographic characteristics including age, number of pregnancies, number of living children, desire for more children, desired number of months for birth spacing, level of education, religion, work and economic status, as well as LAM and transition knowledge, and transition timing. In addition, an average economic index score was derived using select questions from the DHS on housing structure, electricity, water source, land ownership and toilet facilities. Responses were ranked, and an average score was developed for each participant. Scores ranged from 7 (reflecting lowest socio-economic status) to 24 (highest socio-economic status) in Uganda. Scores ranged from 9 to 33 in Guinea.

LAM and Transition Narrative Histories
In both countries, very brief LAM and transition narrative histories were developed from the first 20 transitioner and 20 non-transitioner interviews. These histories helped to better understand the decision-making process around LAM use, and the decision to transition to other modern FP methods. Data from this part of the interview were used to identify critical junctures in the transition decision-making process, to develop descriptive profiles of transitioners and non-transitioners and to identify barriers. Interviews of husbands and mothers-in-law of transitioners and non-transitioners were triangulated with data from transitioners and non-transitioners to further explore the role of social support for the transition.

Barrier Analysis
To identify differences between transitioners and non-transitioners on each behavioral determinant of the LAM transition, odds ratios and the corresponding uncorrected p-values were calculated.

Study Limitations
This study was implemented within the context of country program implementation, utilizing field office staff that had varying degrees of experience with conducting research. In Uganda, this context affected the quality of data collected, particularly with regards to probing for responses. As a result, certain analyses (e.g. – average month of the transition to modern methods, and knowledge about when to transition) in this paper were not included for the Uganda program or did not yield the types of responses sought after. The factors affecting data collection in Uganda, as well as the support provided to address these issues included:

- The team in Uganda was relatively inexperienced in qualitative research and specifically in barrier analysis. An orientation workshop was conducted to familiarize them with the methodology and included practice sessions using the tools for this study.
- The data was collected by a team that was also involved in programming which meant reorganizing their schedules to allow time for the study. The team was led by the M&E advisor with support from the female district coordinator and two extension workers who were familiar with the communities that were selected for the study. The team received ongoing long distance and onsite support from ACCESS-FP BCC Advisor who has led the study in Bangladesh and supported the team in Guinea as well and SC’s FP backstop for the program; both based in DC.

- In the initial phase of the study, the team experienced staff changes that resulted in the loss of a member who was more experienced in qualitative research. This meant identifying someone else within the team to take up her role which was done successfully albeit the person was less experienced.
RESULTS AND FINDINGS

Characteristics of LAM Transitioners and Non-Transitioners
In both countries, there were no significant differences between transitioners and non-transitioners in average age, number of pregnancies, number of living children, or religion. However, there was statistically significant difference in socio-economic status between transitioners and non-transitioners in Guinea. Transitioners tended to have a higher socioeconomic status than non-transitioners (p < 0.05).

There were differences in the participants from both countries that can be observed (Table 1). Regardless of transition status, compared to Guinea, women in Uganda were:
- less likely to desire more children
- more educated (virtually none of the women interviewed in Guinea had any level of education) and also
- interviewed at a later date after the previous birth
Women in Guinea were all Muslim, and tended to be working outside of the home.

Table 1: Characteristics of Transitioners and Non-transitioners

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Uganda</th>
<th></th>
<th>Guinea</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T (n=42)</td>
<td>NT (n=39)</td>
<td>T (n=40)</td>
<td>NT (n=40)</td>
</tr>
<tr>
<td>Mean Age</td>
<td>26</td>
<td>26</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Mean number of pregnancies</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Mean number of living children</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Desire more children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Yes</td>
<td>81.0%</td>
<td>84.6%</td>
<td>95.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>• No</td>
<td>19.0%</td>
<td>15.4%</td>
<td>5.0%</td>
<td>5.0%</td>
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<tr>
<td>Mean number of months after previous birth</td>
<td>39</td>
<td>40</td>
<td>36</td>
<td>33</td>
</tr>
<tr>
<td>Mean number of years of school completed</td>
<td>8</td>
<td>8</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Muslim</td>
<td>16.7%</td>
<td>12.8%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>• Christian</td>
<td>83.3%</td>
<td>87.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working outside the home</td>
<td>59.5%</td>
<td>53.9%</td>
<td>87.5%</td>
<td>85%</td>
</tr>
<tr>
<td>Average Economic Index Score</td>
<td>12.52</td>
<td>12.18</td>
<td>26.10*</td>
<td>23.18*</td>
</tr>
</tbody>
</table>

(Range: Uganda 7 – 24; Guinea 9 – 33)

*p-value less than 0.05
Postpartum, Duration of LAM Use and Transition to Other Methods

Among respondents in Uganda, there were statistical differences regarding the number of months postpartum at the time of the interview. On average, transitioners were interviewed later in the postpartum period (14 months) than non–transitioners (10 months); a factor that could contribute to the transition. In addition, menses had resumed for a greater percentage of transitioners than non-transitioners.

In Guinea, on average transitioners and non transitioners were both nine months postpartum at the time of the study. Further, there were no major differences between transitioners and non transitioners in terms of month postpartum when LAM ended, timing of the introduction of foods, the return of menses and the proportion of babies aged more than 6 months.

The median duration of LAM use was determined by the month postpartum when the first criterion changed. A comparison between the respondents from the two countries indicates that the median duration of LAM use in each country was similar (6 months). Women in Uganda reported transitioning slightly later than those in Guinea, seven months compared to six months (Table 2). However, data are inconclusive regarding the actual month of the LAM transition for Uganda due to missing data for 10 of the 42 transitioners. Among all participants whose menses returned, the average was seven months, except for non-transitioners in Uganda whose menses returned earlier at six months.

Table 2: Period Postpartum, Duration of LAM Use and Timing of Transition by Country

<table>
<thead>
<tr>
<th>CHARACTERISTICS</th>
<th>Uganda</th>
<th>Guinea</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Transitioners (n=42)</td>
<td>Non-Transitioners (n=39)</td>
</tr>
<tr>
<td>Average postpartum month at time of data collection</td>
<td>14** (n=41)</td>
<td>10** (n=39)</td>
</tr>
<tr>
<td>Median PP month when LAM ended</td>
<td>6 (n=41)</td>
<td>6</td>
</tr>
<tr>
<td>Average PP month of reported transition</td>
<td>7 ^ (n=32)</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Criteria changed:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduced foods (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average PP month</td>
<td>90.5% 7</td>
<td>87.2% 7</td>
</tr>
<tr>
<td>Menses returned (%)</td>
<td>95.2%** 7</td>
<td>53.9%** 6</td>
</tr>
<tr>
<td>Baby &gt; 6 months (%)</td>
<td>92.86% 14</td>
<td>82.05% 10</td>
</tr>
</tbody>
</table>

*p-value less than 0.1;**p-value less than 0.05

^ This value is based on n=32 instead of n=42 due to omissions in data collection.
Figures 2 and 3 show a comparison of changes in criteria by transition status for Uganda and Guinea. In Uganda, at the time of the study, significantly more transitioners had resumed menses as compared to non–transitioners (Table 2 and Figure 2). Though not statistically significant, in Guinea women who transitioned were more likely to have experienced a return of their menses as compared to non-transitioners. Non-transitioners on the other hand were more likely to have introduced foods or to have babies older than six months.

**Figure 2: Comparisons of Criteria Changes by Transition Status in Uganda at the time of the study**

![Image of Figure 2](image2)

**Figure 3: Comparisons of Criteria Changes by Transition Status in Guinea at the time of the study**

![Image of Figure 3](image3)
Knowledge of LAM and the Transition to Other Modern Methods

Knowledge
Participants were asked questions to assess their knowledge of LAM and the three criteria. All responses were based on unprompted recall; meaning that women were asked to name the three criteria for LAM. In both countries, all women included in the study knew the name LAM, but there were statistically significant differences in LAM users’ knowledge of the criteria.

Among respondents in Uganda, the criterion most frequently forgotten by both transitioners and non-transitioners was “no menses”. However, non-transitioners in Uganda were more likely to know all three criteria than the transitioners. In Guinea, the criterion most frequently forgotten by both transitioners and non-transitioners was “Baby less than six months.” Very few transitioners or non-transitioners in Guinea knew all three criteria while more respondents in Uganda knew all three criteria regardless of transition status.

Table 3: Unprompted Recall of LAM Criteria by Transition Status

<table>
<thead>
<tr>
<th>CHARACTERISTICS</th>
<th>Uganda</th>
<th>Guinea</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TRANSITIONERS (n=42)</td>
<td>NON-TRANSITIONERS (n=39)</td>
</tr>
<tr>
<td>Know name LAM</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Knowledge of the three criteria:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Breastfeed only</td>
<td>95.2%</td>
<td>94.9%</td>
</tr>
<tr>
<td>• No Menses</td>
<td>57.1%</td>
<td>71.8%</td>
</tr>
<tr>
<td>• Baby &lt; 6 months</td>
<td>95.2%</td>
<td>97.4%</td>
</tr>
<tr>
<td>Know up to 2 criteria</td>
<td>50.0%</td>
<td>35.9%</td>
</tr>
<tr>
<td>Know 3 criteria</td>
<td>50.0%</td>
<td>64.0%</td>
</tr>
</tbody>
</table>

LAM Transition Knowledge
In-depths interviews were used to gain a more in-depth understanding of LAM users’ knowledge about the transition. In Guinea, 20 transitioners and 20 non-transitioners (half of the overall sample) were asked to respond to an open-ended question: “What have you learned about switching from LAM to another modern method?” Responses were categorized into five areas:

1. Benefits of LAM transition:
   • Prevents unplanned pregnancies/used to prevent pregnancy
Spaces future pregnancies

2. When LAM ends switch to another method
   - use FP to prevent pregnancy

3. Makes reference to one or more criteria as a cue to switch:
   - When menses returns
   - after 6-7 months

4. Makes reference to return to sexual activity and return to fertility
   - when sexual activity resumes transition to prevent pregnancy
   - for fertile women, switch after 7 months

5. Timing of LAM transition:
   - At 5 months
   - after 8-9 months
   - after 11 months when the baby begins to walk

6. Doesn’t know

The ambiguity and range of responses to the question revealed that LAM users were more likely to refer to a criteria as a cue to switch to another method and that both transitioners and non-transitioners were aware of the benefits of the transition. However, transitioners and non-transitioners alike had some confusion about the timing of the LAM transition. Non-transitioners were also more likely to respond that they should transition as soon as sexual activity resumed. Please note that the analysis for Uganda is not reported here due to missing data. Figure 4 summarizes responses:

Figure 4. Knowledge about transition by transition status
LAM Transition Decision-Making Process: Timing and Cues
For respondents in Guinea, the decision-making points for transitioning from LAM to another modern FP method were explored in relation to both the timing of the transition and the criteria that cued LAM users to transition. Analysis is not available for Uganda due to missing data.

**Timing of the Transition**
In Guinea for all transitioners (n=40), the timing of the transition was analyzed by graphing the interval between “the actual end of LAM use” and the reported month of transition (Figure 5). The “actual end of LAM use” was calculated based on the reported postpartum month that the first LAM criterion changed. The reported month of the transition reflected the month that the interviewee reported switching to another method. Among the 40 transitioners interviewed, four were early transitioners, switching before any criteria changed. Another 19 were timely transitioners, defined as switching within the same postpartum month as when the first criterion changed. The remaining 17 LAM users were delayed transitioners, defined as waiting one or more months after the first criterion changed before switching to another method. Among the delayed transitioners, about half waited one month after the first criterion changed to switch to another modern method, while the other nine waited two months or more. Thus, a total of 57.5% were early or timely transitioners and the remaining 42.5% were delayed transitioners.

**Figure 5: Interval Between the End of LAM Use and the Transition**

<table>
<thead>
<tr>
<th>Transitions: Interval between the end of LAM use and the transition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>---------------------------------</td>
</tr>
<tr>
<td>No. of transitioners</td>
</tr>
<tr>
<td>Transited by the time</td>
</tr>
<tr>
<td>the first criteria changed</td>
</tr>
<tr>
<td>waited 1 month</td>
</tr>
<tr>
<td>waited 2 months</td>
</tr>
<tr>
<td>waited 3 months or more</td>
</tr>
</tbody>
</table>

**Criteria that Cued LAM Users to Transition in Guinea**
To fully understand which criterion LAM users tended to use as a cue to transition, an analysis was conducted to examine 1) the postpartum month when women reported switching to another modern FP method and 2) which criterion had changed at the time of the reported
transition. Overall among all of the transitioners, only 4 (10%) transitioned before any criteria changed. Among all transitioners, 20 (50%) reported switching before their menses returned, with 15 of the 23 (65.2%) early and timely transitioners switching before a return of menses and only five of 17 (29.4%) of delayed transitioners switching to another modern FP method before menses return. (Tables 4)

Table 4: Cues to Transition Based on Changes in Criteria in Guinea

<table>
<thead>
<tr>
<th>CUES TO TRANSITION</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Early transitioners</strong> (n=4 or 10.0% of all transitioners):</td>
<td></td>
</tr>
<tr>
<td>4 transitioned before any criteria changed</td>
<td></td>
</tr>
<tr>
<td><strong>Timely transitioners</strong> (n=19 or 47.5% of all transitioners):</td>
<td></td>
</tr>
<tr>
<td>1 transitioned when all 3 criteria changed simultaneously</td>
<td>5.3%</td>
</tr>
<tr>
<td>12 transitioned when only 1 criterion changed</td>
<td></td>
</tr>
<tr>
<td>• Menses (n= 5)</td>
<td>26.3%</td>
</tr>
<tr>
<td>• Introduced food (n = 4 )</td>
<td>21.0%</td>
</tr>
<tr>
<td>• Baby &gt; 6 months (n= 3)</td>
<td>15.8%</td>
</tr>
<tr>
<td>6 transitioned when 2 criteria changed simultaneously</td>
<td></td>
</tr>
<tr>
<td>• Introduced foods at 6 months without menses (n= 4)</td>
<td>21.0%</td>
</tr>
<tr>
<td>• Baby &gt;6 months with menses (n= 2)</td>
<td>10.5%</td>
</tr>
<tr>
<td>All 4 early and 11 of the timely transitioners switched before resumption of menses, for a total of 15 (15 out of 23).</td>
<td>65.2%</td>
</tr>
<tr>
<td><strong>Delayed transitioners</strong> (n =17 or 42.5 % of all transitioners):</td>
<td></td>
</tr>
<tr>
<td>• Menses had resumed for 12 of the 17 delayed transitioners before they switched to another method</td>
<td>70.6%</td>
</tr>
<tr>
<td>• 5 of the 17 switched before the resumption of menses</td>
<td>29.4%</td>
</tr>
<tr>
<td><strong>Among all transitioners, 20 out of 40 transitioned before menses resumed.</strong></td>
<td>50%</td>
</tr>
</tbody>
</table>
DESCRIPTION OF TRANSITIONERS

Method Use after LAM
LAM transitioners who participated in the in-depth interviews (n=20) were asked which method they transitioned to after LAM. Most LAM users in Guinea who transitioned reported using combined oral contraceptives followed by injectables. In Uganda, most transitioners switched to injectables followed by combined oral contraceptives. Injectables in Uganda are available through Community Reproductive Health Workers (CRHW). A small portion of the sample in Uganda, 10%, reported using implants. All the transitioners in Uganda were still using the same method. In Guinea, one transitioner had switched from pills to standard days method because of side effects.

More than two thirds of transitioners in Uganda reported having obtained the method from a CRHW while most women in Guinea accessed their method from a health center. Among the focus communities in Guinea, methods were available from a wider range of sources (five) as compared to only three in Uganda (Table 5).
### Table 5: Transitioners’ Use of FP after LAM

<table>
<thead>
<tr>
<th>WHICH METHOD USED AFTER LAM</th>
<th>% LAM TRANSITIONERS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Uganda (n=20)</td>
</tr>
<tr>
<td></td>
<td>Guinea (n=20)</td>
</tr>
<tr>
<td>- Condom</td>
<td>5.0%</td>
</tr>
<tr>
<td></td>
<td>0.0%</td>
</tr>
<tr>
<td>- Pill (COC)</td>
<td>20.0%</td>
</tr>
<tr>
<td></td>
<td>85.0%</td>
</tr>
<tr>
<td>- Injection</td>
<td>65.0%</td>
</tr>
<tr>
<td></td>
<td>15.0%</td>
</tr>
<tr>
<td>- Implant (Norplant)</td>
<td>10.0%</td>
</tr>
<tr>
<td></td>
<td>0.0%</td>
</tr>
<tr>
<td>- IUD</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>0.0%</td>
</tr>
<tr>
<td>- Female Sterilization</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>0.0%</td>
</tr>
<tr>
<td>- Male Sterilization</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>0.0%</td>
</tr>
<tr>
<td>- Other</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Still using the same method</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>95.0%</td>
</tr>
<tr>
<td>No</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>5.0%*</td>
</tr>
<tr>
<td>*switched from pills to the standard days method because of side effects</td>
<td></td>
</tr>
<tr>
<td><strong>Where obtained method</strong></td>
<td></td>
</tr>
<tr>
<td>CRHW/Community agent</td>
<td>70.0%</td>
</tr>
<tr>
<td></td>
<td>15.00%</td>
</tr>
<tr>
<td>Health centre/health facility</td>
<td>10.0%</td>
</tr>
<tr>
<td></td>
<td>65.00%</td>
</tr>
<tr>
<td>Surgical camp</td>
<td>5.0%</td>
</tr>
<tr>
<td></td>
<td>0.0%</td>
</tr>
<tr>
<td>Friends (Standard days method)</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>5.00%</td>
</tr>
<tr>
<td>Market pharmacy</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>15.00%</td>
</tr>
<tr>
<td>TBA/Village midwives</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>5.00%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>15.00%</td>
</tr>
<tr>
<td></td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Cost of FP method</strong></td>
<td>FP methods are free within the public health system</td>
</tr>
</tbody>
</table>

### Profiles of Transitioners based on in-depth interviews

**Uganda**

A total of 23 transitioners participated in in-depth interviews. Originally 20 were scheduled, but during the course of the study three LAM users identified as non-transitioners were reclassified as transitioners, as they had transitioned to using condoms periodically since their husbands
were away. Just under half of the transitioners who participated in in-depth interviews were timely transitioners (10), and a few were delayed (7). One LAM user transitioned early. A few interviewees were identified as women whose husbands were away and transitioned to condom use as needed (3). The timing of two participants’ transition was unclear.

**Early transitioner**
The early transitioner was a low parity, 25 year old with a two year old and eight month old, who desired more children. She received encouragement to transition to injectables from her husband based on their current experience with closely spaced pregnancies.

> “Start Depo because the rate at which you are giving birth is alarming. You gave birth to the second born when the first was a year and 1 half”

(Comment from husband of 25 year old low parity, LAM transitioner; eight months postpartum; two pregnancies; two living children)

**Timely transitioners**
Among the ten timely transitioners interviewed, five were high parity, and five were low parity. Two intended to limit future pregnancies, while the remaining reported that the desire to have another child and were spacing the next pregnancy. Of the 10, the majority transitioned with the resumption of their menses (9), while one transitioned before menses when her baby was 6 months. All but one participant chose Depo Provera (Depo). The other transitioned to pills.

Most perceived severe consequences for pregnancies spaced less than six months after the last delivery, but only two LAM transitioners reported a pregnancy occurring 7 to 24 months after the previous birth as very serious. For all these participants, consequences included: sickness and malnutrition resulting from early weaning, inability to equally distribute love between both babies with the elder suffering most.

Motivations for and perceived benefits of transitioning in order to space or limit pregnancies varied among the interviewees. Factors cited included:

- having enough time to engage in income generating activities
- improving ability to earn family income
- ability to educate children
- having increased ability to afford basic necessities in the home
- improved health of children
- having a stress free life
- being able to plan for the family’s future
- difficulty looking after a large a family
- having ample time to rest after giving birth
• having enough time to organize your home
• better ability to give love and attention to children
• previous experience of suffering with closely spaced pregnancies, both physically as a mother and economically (limiting)

[Jane] conceived when her baby was nine months, and was sick and vomited all of the nine months she carried her pregnancy, which affected the baby as it became malnourished and... was born with a low birth weight. This affected her economically as well, because even the money she earned from tailoring was cut off because she was not working...She used up all her savings...

(Experience of 19-year-old; low parity; LAM transitioner; nine months postpartum; two pregnancies; two living children; desire to limit future pregnancies)

• bringing children into a poor home

“...If couples are poor, they should not bring innocent children into this world to make them suffer”.

(30-year-old; high parity; LAM transitioner; one year postpartum; five pregnancies; five living children; desire to space future pregnancies)

• remaining attractive to one’s husband

“You look nice for your husband but when you have too many children, your husband gets tired of you, starts comparing you to a rabbit and gets fed up with you”

(22-year-old; high parity; LAM transitioner; four months postpartum; three pregnancies; three living children)

The sources of social support for timely transitioners varied. Women reported receiving support from their husbands in the majority of cases, with eight of 10 participants reporting support or encouragement to transition to other methods from their husbands. Two timely transitioners noted that their husbands were against family planning and both chose to use Depo without their husband’s knowledge. Respondents also reported receiving support from a variety of other sources such as community health extension workers, mothers, grandmothers, elder women, aunties, friends, sister-in-law, brothers, sisters and teachers.
Having discussed the transition with her husband, she felt good and loved, because he didn’t want her to conceive at four months after delivery.

(Report from a 27-year-old; low parity; LAM transitioner; four months postpartum; two pregnancies; two living children)

Delayed transitioners
Of the seven delayed transitioners interviewed, all reported a desire for more children. Four were high parity and three were low parity. One delayed transitioner reported that she did not live with her husband. Two others who reported delaying the transition avoided discussing it with their husbands because of the husbands’ disapproval of family planning. However, the husband’s disapproval was for different reasons. One husband had misconceptions about family planning having affected the death of one of his children. This LAM user transitioned to Depo so she could use it clandestinely.

“Those injections you took to avoid getting pregnant led to the death of our second born.”

(Comment from husband of 25-year-old; high parity; LAM transitioner; one year postpartum; three pregnancies; two living children)

The other delayed transitioner eventually decided to use injectables because her husband was not giving her money to take care of their 3 girls and wanted her to continue to bear children without spacing until they had a male child.

“You will see the color of my money when you give birth to a boy”

(Comment from husband of 32-year-old; high parity; LAM transitioner; —one year postpartum; three pregnancies; three living children)

Four of the remaining delayed transitioners explicitly noted their husband’s support for using a method, often motivated by the need to have the financial resources to take care of their families. One participant’s husband accompanied her to obtain a surgical implant. None of these interviewees mentioned why they delayed the transition. However, three transitioned within two months after menses resumed and for one menses had not yet returned.

“Me, I am giving you advice to go and have your tubes tied. We have 3 children and I also have to take care of my deceased
brother’s 2 children. If you continue having children, we might fail to educate all of them”

(Comment from husband of 38-year-old; high parity LAM transitioner; one year postpartum; three pregnancies; three living children)

“We won’t be able to look after the children we have, let’s give it a break.”

(Comment from husband of 27-year-old; high parity; LAM transitioner; one year postpartum; six pregnancies; four living children)

Transition to condoms
Three women (two high parity and one low parity) transitioned to condom use due to the fact that they were not living with their husbands. In the two high parity cases, the husbands were involved in the decision. Two of these women are not included in the quantitative analysis of 42 transitioners, because study sample size had already been reached. However, their narratives are included in the qualitative analysis as they help to illustrate one type of situation that may arise for other women transitioning from LAM to other modern methods.

The low parity transitioner was a younger high school dropout due to pregnancy, living with her mother and planning to return to school. She would use condoms whenever she met with her husband. Fear of stigma by facility based service providers has prevented her from seeking her method of choice. While she could access the service from a community based provider, CRHWS in the program were reluctant to provide services to women under 18 because of concerns community members might be opposed to the provision of services to minors.

“If an older person such as my mother came with me, I would have the courage to go to the health center get Depo. When I went there, the HW commented that I was too young to be using Depo which discouraged her and led to an unwanted pregnancy.”

(17-year-old; low parity; LAM transitioner; one year postpartum; one pregnancy; one living child)

Guinea
A total of 20 transitioners participated in in-depth interviews, the majority of whom transitioned early (n=2) or within the same month that the first criteria changed (n=13). Only

LAM and the Transition Barrier Analysis 22
four of the women participating in the interviews transitioned a month or more after the first criteria changed and the timing of one participant’s transition was unclear.

The majority were in polygamous relationships (n=16) and all but two reported a desire for more children. Just over half (n=12) reported discussing the transition with their husbands, one quarter mentioned discussing the transition with friends and another quarter reported making the decision alone. Among those who did not discuss with their husbands, the most common reason was that he would not accept it because he thought about FP only for limiting pregnancies. Another quarter of the women did involve their husbands in the decision-making, even though they felt he would refuse. More than half of the women reported going to obtain the method themselves (70%). A little over half transitioned to the method they had used prior to this pregnancy (n=13). The majority of the women (n=17) reported transitioning to pills. All reported that they had resumed sexual activity, with most stating that it was periodic (n=17). Over half indicated that they had resumed with in the first 4 months postpartum.

Early transitioners
Both of the early transitioners (n=2) were high parity women who were living in polygamous relationships and had resumed periodic sexual activity 40 days after the birth of their last baby. Their husbands both encouraged them to use family planning after LAM during the decision-making process. In one case, the polygamous relationship influenced the decision to transition.

“I was happy because he told to use a method so we can have sexual relations without becoming pregnant...By using contraceptives, both of us can have sexual relations with our husband” source

(37-year-old; high parity; LAM transitioner; nine months postpartum; four pregnancies; four living children)

Timely Transitioners
Among the 13 timely transitioners, six were low parity and seven were high parity. Among the women who transitioned without menses, awareness of the risk of pregnancy was mentioned as a motivating factor for transitioning.

“I was told that if you don’t have your menses, you can become pregnant if you have sexual relations and if you do not use another modern method”

(30-year-old; high parity; LAM transitioner; eight months postpartum; nine pregnancies; six living children)

Other motivators for women who switched after menses resumed included sexual relations in a polygamous relation. Fear of pregnancy while their baby was still young was also mentioned.
“My co-wife had sexual relations with my husband after my delivery. Since I wanted to have them also, as soon as my baby was 3 months old, I went to obtain a family planning.”

(16-years-old; low parity; LAM transitioner; eight months postpartum; one pregnancy; one living child)

Delayed transitioners
Very few LAM transitioners who were interview had actually delayed the transition. Among those who did delay, the following reasons were mentioned: waiting for menses and not being sexually active – either because of postpartum abstinence (2) or the husband being away.

Waiting for menses
One LAM users described waiting for menses before transitioning along with her desire to prevent pregnancy while her child was so young. This was similar to how several non-transitioners described waiting for menses.

Postpartum abstinence
Women sometimes referred to postpartum abstinence as “double protection” against pregnancy in addition to LAM. It also sometimes delayed the transition, because women did not perceive themselves at risk during the postpartum abstinence period. This theme was also heard in non-transitioner narratives.

“I made the decision [to transition] at 10 months, because I had not resumed sexual relations.

(16-years-old; low parity; LAM transitioner; ten months postpartum; one pregnancy; one living child)
DESCRIPTION OF NON-TRANSITIONERS

Uganda:
Profiles of non-transitioners in Uganda
In Uganda, the majority of non-transitioners reported their desire for another child. With regards to the LAM transition, they reported discussing and being influenced in their decision about the transition by a wide range of people including their husbands, friends, mothers, CRHW, aunt, sisters- in-law, and sisters. Almost one half reported that friends influence their decisions about birth spacing (n =19) and just over a third reported that friends influence decisions about family planning (n=15). Prior to the most recent birth, less than half of the non-transitioners interviewed (n=8) had ever tried to use a family planning method to prevent pregnancy.

Barriers to the transition in Uganda
In Uganda, during in-depth interviews, the majority of the 20 non-transitioners who participated in the in-depth interviews reported both their desire to space (n=16) and limit future pregnancies (n=4). Participants indicated nine reasons for not transitioning: waiting for menses (n=6), limited availability of methods (n=2), belief that breastfeeding protects from pregnancy (n=2), menses had just recently resumed (day before or same day as interview) and they had not had time to transition (n=2), misconceptions about methods (n=1), lack of support from husband (n=1), low perceived risk of pregnancy due to the husband being away (n=1), concern about side effects of method use (n=1), short lapse in non-LAM use after feeding a three month baby, who was ill, with cow milk for two days (n=1), and misunderstanding of the LAM criteria (n=1).

Waiting for menses
Waiting for menses to return was the most common reason given for not transitioning. Almost half (9) of the 20 non-transitioners interviewed stated that this was their primary reason. There were several reasons why non-transitioners mentioned they were waiting for menses. One was based on a belief in their own personal fertility pattern.

“...the last time [after] I got my menses, I got pregnant.”

(comment from 22-year-old; low parity; LAM non-transitioner; nine months postpartum; three pregnancies; two living children)

Other non-transitioners believed they could not conceive without the resumption of menses, with one describing menses as a symbol of “return to fertility.” One non-transitioner was waiting for menses because she was not sure if she had already conceived or not.

Lack of availability of methods
With regard to the availability of methods, two women described their unsuccessful attempts to obtain methods. In particular, one participant mentioned a delay in the quarterly surgical
camp (where longer acting methods are available free of charge). The other mentioned that Depo was out of stock twice when she went to obtain it.

**Breastfeeding prevents pregnancy**
Two non-transitioners believed that women are not able to conceive if they are currently breastfeeding.

**Recent return of menses**
Two participants stated that their menses had just resumed within the last day and both were intending to transition.

**Misconceptions about family planning**
One non-transitioner had heard a rumor from her husband about infertility resulting from FP use. According to him and neighbors who confirmed the rumor, a woman who has only one child and who uses FP would,

> “Bleed for a month...all her eggs would be lost in the process and she might not ever be able to have children...”

(Comment from 24-year-old; high parity; LAM non-transitioner; five months postpartum; three pregnancies; three living children)

**Lack of support from husband**
The non-transitioner who reported lack of support from her husband as the primary reason for not transitioning explained that her husband is very poor and wants many children to look after him in the future.

**Husband away**
In consultation with her friend and sister, one high-parity 24 year old non-transitioner decided not to transition because she lives away from her husband and thus did not “fear any risk of pregnancy.”

**Side effects**
Despite her husband’s efforts of support, one non-transitioner who had already experienced bleeding when using a method, refused to transition because her friends told her she would have side effects. These warnings caused her to neglect the transition process.

> “You can manage to take a goat to graze amidst protests, but you cannot get it to eat grass even if it’s good for it.”

(Comment from husband of 22-year-old; low parity; LAM transitioner; one year postpartum; three pregnancies; two living children)
**Misunderstood LAM transition criteria** –
One non-transitioner reported misunderstanding the LAM criteria, but provided no additional information.

**Baby was sick**
In one situation, a baby was sick and refused breast milk for 2 days so the mother gave cow’s milk. However, she didn’t switch from LAM to a modern FP method because the lapse in breastfeeding had only lasted for 2 days. Also since her menses didn’t return she thinks LAM is still working well for her. *(Experience of 23-year-old; low parity; LAM transitioner; three months postpartum; two pregnancies; two living children)*

**GUINEA:**

**Profiles of Non-Transitioners: Guinea**
In Guinea, almost all of the LAM non-transitioners desired more children. They tended not to discuss the decision to transition with anyone, not even their husbands. Many mentioned they thought their husbands would refuse, while others did not think of it as a topic to discuss with them. Prior to the most recent birth, very few (n=3) reported ever trying to use a method to prevent a pregnancy.

**Barriers to the transition in Guinea**
During in-depth interviews, participants indicated nine reasons for not transitioning: lack of information on other modern methods (4), availability of methods (5), waiting for menses/fertility pattern (4), sexual inactivity due to marital difficulties (3), fear of informing spouse (2), financial constraints (1), and concerns about sterility (1).

**Lack information on other modern methods**
Four non-transitioners described the lack of sufficient information about other modern methods as their principal barrier. For two participants, their menses had already resumed and they identified a need for information on methods. However, at least two participants were not concerned about the lack of information as of yet because of what they called “double protection.” This double protection referred to a delay in postpartum sexual activity, which also served to protect them from pregnancy.

“I don’t see my menses early and my husband will not have sexual relations yet. So we have LAM, but even if we don’t we cannot become pregnant...when my child walks, that’s the time we can resume sexual relations.”

*(Comment from 18-year-old; low parity; LAM non-transitioner; nine months postpartum; two pregnancies; two living children)*
Availability of methods
Difficulty accessing FP methods due to stock outs, preference for receiving methods in the household or working in the mines for an extended period of time was raised by five non-transitioners. LAM non-transitioners identified several issues related to having access to methods. Working in the mines was common among women in this region of Guinea. In some cases, LAM non-transitioners spent extended periods of time away from home and had difficulty traveling to obtain methods. Two participants mentioned this as a principal barrier. Another two participants raised the issue that health workers did not have contraceptives to bring to the household, in some cases due to stock outs.

“The members of the Village Health Committee no longer have methods and I have to go 25 km [to the health center]. I did not have anyone to accompany me there and I was afraid to go alone.”

(comment from 25-year-old; high parity; LAM non-transitioner; seven months postpartum; five pregnancies; three living children)

Waiting for menses/fertility pattern
Four non-transitioners highlighted beliefs about natural fertility patterns that influence women’s decisions to switch to a modern method. There were names assigned to women based on these natural fertility patterns as well. “Sula muso,” or a woman who conceives like a monkey, refers to women who experience return to fertility early. The terms “Si muso/sigui muso/siki muso” refer to women who conceive later like buffalo and do not become pregnant with a child before calf reaches the top of the thigh. Women identified themselves with these descriptions of natural fertility patterns.

“I will not stop using LAM until my child is 1 year and 5 months. ...if I don’t see my menses, I cannot become pregnant.”

(Comment from 28-year-old; high parity; LAM non-transitioner ; eight months postpartum; four pregnancies; four living children)

For me, when you see your period, it is time to transition... but if it is a fertile woman, that is a woman who becomes pregnant easily before her baby starts to walk, she needs to [switch] at 7 months...For me; I don’t become pregnant until 8 months. That’s why I did not transition.

(Comment from 22-year-old; low parity; LAM non-transitioner; eleven months postpartum; two pregnancies; one living child)

Not sexually active due to marital difficulties
Three women were not sexually active with their husbands at the time of the study, and therefore thought that they did not need to transition,
Fear of informing spouse
Two LAM non-transitioners cited fear of telling their husband as the reason for not transitioning. One mentioned that her husband’s lack of support was due to his belief that taking pills is akin to an abortion.

Financial constraints
Only one LAM user cited financial constraints as the reason she had not transitioned. Women in Guinea have to pay for methods and also for transport to the health center if the method is not available at the community level.

Concerns about sterility
One participant stated that the primary reason she did not transition was her fear of infertility.

Other influences on the transition: the social context and postpartum abstinence traditions

Influence of co-wives in Guinea
Interview findings suggest co-wives can facilitate the transition as a source of information, a role model or competition with regards to the sexual relationship with the spouse.

“I discussed it with my co-wife. She said to my husband we should plan. So I will ask at the health center and discuss it with my co-wife so we can make the decision together.” (Young, low-parity woman)

(18-year-old; low parity; LAM non-transitioner; ten months postpartum; one pregnancy; one living child)

Resumption of sexual activity
In contrast to trends seen in DHS data and despite cultural traditions of postpartum abstinence, almost all transitioners and non-transitioners reported having resumed sexual activity within the first year postpartum. More than half of the transitioners resumed sexual activity by 3 months postpartum. More than half of the non-transitioners resumed activity by 5 months postpartum.
BARRIERS AND FACILITATORS OF LAM TRANSITIONS

An analysis of barriers to the transition explored nine determinants of the LAM transition and was triangulated with results from the in-depth interviews. The analysis indicated **statistically significant differences** between the transitioners and non-transitioners regarding their perceptions of the following: the timing of their personal risk for pregnancy after a birth, vulnerability to pregnancy when each criterion changes, social support for the transition, and the advantages and disadvantages of the transition (Table 6).

Barriers and Facilitators to LAM Transition: Guinea

Table 6: Key Differences in Barriers by Transition Status – Guinea

<table>
<thead>
<tr>
<th>DETERMINANTS</th>
<th>TRANSITIONERS (%) n=45</th>
<th>NON-TRANSITIONERS (%) n=36</th>
<th>p-VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceptions of the timing of their personal risk for pregnancy after a birth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can only become pregnant if do not use LAM or a FP method more than 1 year after delivery</td>
<td>18.0%</td>
<td>38.0%</td>
<td>0.045</td>
</tr>
<tr>
<td>Perceived vulnerability to pregnancy when each criteria changes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinks she can become pregnant if does not switch from LAM to another method when INTRODUCES OTHER FOODS</td>
<td>100%</td>
<td>85%</td>
<td>0.010</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>83%</td>
<td>0.005</td>
</tr>
<tr>
<td>Perceived self-efficacy for the transition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at all difficult to remember to transition</td>
<td>88%</td>
<td>48%</td>
<td>0.000</td>
</tr>
<tr>
<td>Husband makes it more difficult</td>
<td>5%</td>
<td>25%</td>
<td>0.012</td>
</tr>
<tr>
<td>Husband made it easier</td>
<td>45%</td>
<td>3%</td>
<td>0.000</td>
</tr>
<tr>
<td>Perceived social acceptability of the transition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When any one of the 3 criteria changes, she thinks most of the people that she</td>
<td>100%</td>
<td>90%</td>
<td>0.040</td>
</tr>
</tbody>
</table>
## DETERMINANTS

<table>
<thead>
<tr>
<th></th>
<th>TRANSITIONERS (%) n=45</th>
<th>NON-TRANSITIONERS (%) n=36</th>
<th>p-VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>knows support/would not support of her transitioning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Who would support:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends</td>
<td>15%</td>
<td>0%</td>
<td>0.011</td>
</tr>
<tr>
<td><strong>Who would not support:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-wife</td>
<td>0%</td>
<td>10%</td>
<td>0.040</td>
</tr>
</tbody>
</table>

All findings were significant at a *p<.05.

Findings from data collected through barrier analysis semi-structured questionnaires indicated that:

**Transitioners were significantly more likely to:**

1. Perceive that they could become pregnant if they did not switch to another method when the introduction of foods occurred and the baby was >6 months.
2. Perceive that they had social support for using a method, and that husbands’ support made the transition easier.
3. Perceive they could easily remember to transition.

**Figure 6: Perceptions of Pregnancy Vulnerability If Do Not Switch to Another Method after LAM, by Transition Status, in Guinea**

![Figure 6 - Perceptions of Pregnancy Vulnerability](image)

**Thinks she can become pregnant if she does not switch to another method when...**

- Menses returns: 100% Transitioners, 98% Non-Transitioners
- Introduces other foods: 100% Transitioners, 85% Non-Transitioners
- Baby > 6 months: 100% Transitioners, 83% Non-Transitioners
Non-transitioners were more likely to:
1. Believe that they were only at risk for pregnancy 1 year or more after a delivery, if not using LAM or another FP method.
2. Report that their husbands made the transition difficult.

Social support:
Transitioners were more likely to perceive support from friends and non-transitioners were more likely to report that their co-wives would not support the transition. In addition, all but two non-transitioners reported making the decision not to transition without anyone’s assistance.

Figure 7: Comparison of Perceptions of Fertility Return by Transition Status in Guinea

Barriers and Facilitators to LAM Transition: Uganda
The findings from the analysis of the nine determinants in Uganda revealed three statistically significant differences between the transitioners and non-transitioners. Non-transitioners were more likely to perceive the consequences of closely spaced births and report side effects as a disadvantage of transitioning. Transitioners were more likely to perceive they could easily remember to transition.
<table>
<thead>
<tr>
<th>DETERMINANTS</th>
<th>TRANSITIONERS (%) n=42</th>
<th>NON-TRANSITIONERS (%) n=39</th>
<th>p-VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived severity of closely spaced births 7 – 12 months postpartum</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| “Weak womb”*  
Body will not have enough time to rest**                            | 0%                      | 8%                          | 0.067   |
|                                                                           | 10%                     | 0%                          | 0.048   |
| Cues to Action: Thinks it was difficult to remember to transition **       |                         |                             |         |
| Not difficult                                                             | 90%                     | 62%                         | 0.002   |
| (n=38)                                                                    | (n=35)                  |                             |         |
| Perceived disadvantages of transitioning: **                               |                         |                             |         |
| Other FP methods have side effects                                        | 10%                     | 33%                         | 0.008   |

Table 7: Key Differences in Barriers by Transition Status in Uganda

* *p*-value less than 0.1
** *p*-value less than 0.05
CONCLUSIONS AND RECOMMENDATIONS

Key Findings

Decision Making Process, Cues to Transition and Social Context:

- In Guinea, more than half of the women switched to another method before or as soon as the first criterion changed.
- The return of menses remains an important cue to transition as was found also in the Bangladesh study. In Guinea, it was the most frequently cue mentioned by women though over half of the transitioners switched before menses returned. In Uganda, in-depth interviews with non-transitioners identified waiting for menses as the main reason for not switching.
- It is important to take into account the social context when addressing barriers or facilitating the transition. This study revealed varying sources of social support, dynamics in decision-making with husbands, and the influence of polygamy. In Guinea, almost all women worked and many were able to move about independently to obtain methods.
  - Husband could be an important source of social support and encouragement.
  - Unexpectedly, older co-wives in polygamous relationships sometimes served as role models for family planning use, as opposed to competition to match in childbearing. In some cases, this could be used to support the LAM transition.
- The resumption of postpartum sexual activity in the study community in Guinea may be earlier than traditionally observed long postpartum abstinence periods. Over half of the women in the study reported being periodically sexually active within the first 3 months postpartum. Women in Uganda reported resuming sexual activity around the same period due to pressure from their husbands or concerns about infidelity; particularly important in a country with a high HIV prevalence.

Barriers to the Transition

Key barriers to a timely transition include:

- For Guinea, the main reasons cited were:
  - lack of information on other modern methods,
  - difficulty accessing methods,
  - waiting for menses/fertility pattern,
  - lack of sexual activity because of marital difficulties,
  - fear of informing spouse and
  - perceived lack of support from their husbands or co-wives.
- For Uganda, the main reasons cited were:
  - waiting for menses,
  - fear of side effects,
  - misconceptions or rumors about modern methods,
  - perception that one cannot conceive if the baby is still breastfeeding and
Lack of support from the husband.

- Financial concerns were rarely mentioned in either country.

Recommendations

Areas that need to be addressed:

- Menses return or personal fertility patterns as determinants: Findings highlight that women often wait for menses to return or strongly rely on personal fertility patterns as determinants of when to switch to another method. This is the case even when they have knowledge about the LAM transition. Messaging should clarify and further emphasize that:
  - there is the risk of pregnancy prior to menses
  - breastfeeding alone does not protect from pregnancy
  - the timing of the risk of pregnancy after a birth varies from pregnancy to pregnancy
  - risk of pregnancy does not depend on personal fertility patterns (Guinea)

- Difficulty accessing methods in Guinea: Women in Uganda are able to access injectables from community health workers. Programs in Guinea should:
  - increase efforts to expand the method mix, such as community based distribution of injectables
  - ensure women who work away from home (mining) are able to access contraceptive methods.

- Concerns about side effects in both countries: There is a need for better counseling so that women are aware and know what to expect in terms of side effects.

- Norms for postpartum return to sexual activity: Interventions should take into account shifting norms in the resumption of sexual activity during the postpartum period and ensure that women have the information and methods they need early enough to transition in a timely manner.

- Lack of social support: better involvement of men in both countries, involving mothers in law (Uganda) or co-wives (Guinea). In addition, interventions should include other sources of social support, such as friends (Uganda and Guinea) and other relatives (Guinea), to helping facilitate transition for women.
Annex I: Sites selected in Uganda and Guinea

Uganda

<table>
<thead>
<tr>
<th>No</th>
<th>District</th>
<th>Parish</th>
<th>Village</th>
<th>Distance to District admin offices (Km)</th>
<th>Ethnic Group</th>
<th>Socio-economic activities</th>
<th># health units</th>
<th># Community Reproductive Health Workers</th>
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</thead>
<tbody>
<tr>
<td>01</td>
<td>Nakasongola</td>
<td>Nalukooge</td>
<td>Moone</td>
<td>40</td>
<td>Baruli</td>
<td>Fishing</td>
<td>0</td>
<td>2</td>
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<tr>
<td>02</td>
<td>Nakasongola</td>
<td>Irima</td>
<td>Irima</td>
<td>25</td>
<td>Baruli</td>
<td>Fishing</td>
<td>0</td>
<td>1</td>
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<tr>
<td>03</td>
<td>Nakasongola</td>
<td>Kyeyindula</td>
<td>Kyeyindula</td>
<td>25</td>
<td>Semi-Urban</td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>04</td>
<td>Nakasongola</td>
<td>Nabiswera</td>
<td>Njeru</td>
<td>55</td>
<td>Pastoralists</td>
<td></td>
<td>1</td>
<td>1</td>
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<tr>
<td>05</td>
<td>Nakasongola</td>
<td>Mayirikiti</td>
<td>Mayirikiti Trading Center</td>
<td>30</td>
<td>Baruli</td>
<td>Semi-Urban</td>
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<td>1</td>
</tr>
<tr>
<td>06</td>
<td>Luwero</td>
<td>Kalanamu</td>
<td>Kalungu</td>
<td>25</td>
<td>Farming</td>
<td></td>
<td>0</td>
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<tr>
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<td>Degeya</td>
<td>Kitenderi</td>
<td>30</td>
<td>Baganda</td>
<td>Farming</td>
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<td>1</td>
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<tr>
<td>08</td>
<td>Luwero</td>
<td>Kayindu</td>
<td>Kyampisi</td>
<td>25</td>
<td>Baganda</td>
<td>Farming</td>
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<td>2</td>
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<tr>
<td>09</td>
<td>Nakaseke</td>
<td>Kinyogoga</td>
<td>Kinnyogoga Trading center</td>
<td>60</td>
<td>Banyankole</td>
<td>Pastoralists</td>
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<td>1</td>
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<tr>
<td>10</td>
<td>Nakaseke</td>
<td>Kamuli</td>
<td>Kamuli</td>
<td>10</td>
<td>Baganda</td>
<td>Farming</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>N 0</td>
<td>Sub Prefectures</td>
<td>Total Population</td>
<td>Distance to Prefecture main city (Km)</td>
<td>Distance from Kankan (Km)</td>
<td>Geographical location</td>
<td>Ethnic group</td>
<td>Socio-economic activities</td>
<td>Religion</td>
</tr>
<tr>
<td>-----</td>
<td>--------------------</td>
<td>------------------</td>
<td>---------------------------------------</td>
<td>---------------------------</td>
<td>---------------------------------</td>
<td>--------------</td>
<td>---------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>0</td>
<td>Saladou</td>
<td>20,052</td>
<td>85</td>
<td>170</td>
<td>River Crossing 6h</td>
<td>Peulh from Wassolon</td>
<td>Saladou and Morodou : Agriculture (rice, peanuts, maize and cashew nuts)</td>
<td>Islam - some Christian in Mandiana Urban Commune</td>
</tr>
<tr>
<td>0</td>
<td>Morodou</td>
<td>22,973</td>
<td>25</td>
<td>112</td>
<td>SUD (Wassolon region)</td>
<td>Mandiana : commerce and artisanal mining</td>
<td>Mandiana : commerce and artisanal mining</td>
<td>Islam - some Christian in Mandiana Urban Commune</td>
</tr>
<tr>
<td>0</td>
<td>Mandiana Urban Commune Main City</td>
<td>20,180</td>
<td>0</td>
<td>85</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>0</td>
<td>Kinieran</td>
<td>34,739</td>
<td>90</td>
<td>125</td>
<td>NORD (Manding region)</td>
<td>Maninka</td>
<td>Agriculture (mainly rice and maize) and tradition al mining</td>
<td>Islam predominant - some few Christians in Kinieran</td>
</tr>
<tr>
<td>0</td>
<td>Dialakoro</td>
<td>51,280</td>
<td>140</td>
<td>175</td>
<td></td>
<td></td>
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<td>5</td>
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</tbody>
</table>
## Annex II: Summary of instruments used in the analysis

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Method</th>
<th>Intended Audience</th>
<th>Purposes</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAM transition Screening form</td>
<td>One-on-one interview</td>
<td>LAM users</td>
<td>To determine study eligibility by screening for LAM transitioners and non-transitions among LAM users.</td>
</tr>
<tr>
<td>LAM transitioner interview guide</td>
<td>One-on-one interview</td>
<td>LAM transitioners</td>
<td>To understand the process of deciding to transition to another modern method.</td>
</tr>
<tr>
<td>LAM non-transitioner interview guide</td>
<td>One-on-one interview</td>
<td>LAM non-transitioners</td>
<td>To understand the process of deciding not to transition to another modern method.</td>
</tr>
</tbody>
</table>
| Barrier analysis questionnaires | Semi-structured questionnaire | LAM transitioners and non-transitioners | To identify barriers to the LAM transition with a focus on:  
  - Perceived susceptibility to pregnancy  
  - Perceived severity of closely spaced births  
  - Perceived efficacy of timely transition to spaced pregnancy and prevent unintended pregnancy  
  - Perceived social acceptability of the transition to other modern methods (i.e. – FP use)  
  - Perceived self-efficacy for LAM use and the transition  
  - Cues for action to transition  
  - Perception of divine will  
  - Positive attributes of the transition  
  - Negative attributes of the transition |
| Husband interview guide         | One-on-one interview    | Husbands of transitioners and non-transitioners | To gain an understanding of LAM transitioner and non-transitioner husbands’ participation in intervention activities  
  - To determine husbands’ knowledge about exclusive breastfeeding, LAM and the transition  
  - To determine husbands’ support of LAM and the transition |
<p>| Mother-in-law (MIL) interview guide | One-on-one interview    | MILs of transitioners and non-transitioners | To gain an understanding of LAM transitioner and non-transitioner MILs’ participation in intervention activities |</p>
<table>
<thead>
<tr>
<th>Instrument</th>
<th>Method</th>
<th>Intended Audience</th>
<th>Purposes</th>
</tr>
</thead>
</table>
|            |        |                  | • To determine MILs knowledge about exclusive breastfeeding, LAM and the transition  
|            |        |                  | • To determine MILs support of LAM and the transition |

Annex III: Lexicon of terms from the qualitative research in Guinea

<table>
<thead>
<tr>
<th>N0</th>
<th>Local terms</th>
<th>Translation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Si muso</td>
<td>Buffalo woman</td>
<td>This type of woman will only conceive when her youngest child is as tall as her hip</td>
</tr>
<tr>
<td>2</td>
<td>Tun kundunin den</td>
<td>Small child “butts”</td>
<td>This type of woman conceives unknowingly while she is amenorrheic. To ensure the survival of her children, she collects herbs and burns them with the goal of chasing evil away</td>
</tr>
<tr>
<td>3</td>
<td>Dji kè soloda do</td>
<td>Putting water in the kettle</td>
<td>Exclusively breastfeeding for 6 months, absence of menses, baby less than 6 months</td>
</tr>
<tr>
<td>4</td>
<td>Sin min</td>
<td>Breastfeed the baby</td>
<td>Breastfeed the baby as needed and continuously</td>
</tr>
<tr>
<td>5</td>
<td>Bon nadon</td>
<td>Entry into the bedroom</td>
<td>Resumption of sexual activity after delivery</td>
</tr>
<tr>
<td>6</td>
<td>Moso la koli yebaliya den na sin min wati</td>
<td>Period of amenorrhea after delivery</td>
<td>These women do not use contraception because of the belief that they cannot become pregnant until their menses return</td>
</tr>
</tbody>
</table>
| 7  | Sede                          | Malnutrition                | Certain conditions in children such as diarrhea, wasting, etc are attributed to the early resumption of sexual activity by the mother (generally before 1 year postpartum)  
|    |                               |                              | Or if the mother conceives while her last child is still breastfeeding; any disease/condition in this index child is attributed to the fact that the mother is pregnant                                      |
| 8  | Kun yèdè ma                   | Abstain from sexual activity while the baby is still breastfeeding | These women refrain from sexual activity with their spouse for fear that she will become pregnant or that her breastfeeding baby may become malnourished |

*LAM and the Transition Barrier Analysis*