Assessing the impact of introducing the Standard Days Method in India, Peru and Rwanda

Background

The Standard Days Method (SDM) is a fertility awareness-based method developed and tested by the Institute for Reproductive Health at Georgetown University that is appropriate for women with most menstrual cycles between 26 and 32 days long. It identifies days 8 to 19 of the menstrual cycle as the "fertile window", i.e., the days when pregnancy is very likely. To prevent pregnancy, the couple avoids unprotected intercourse during the 12-day fertile window. The 12 days take into account the life span of the woman's egg, the viable life of sperm, and the variation in the actual timing of ovulation from one cycle to the next.[1] Most women who use the SDM find that CycleBeads, a visual aid that represents the menstrual cycle, are helpful for learning and using the method. CycleBeads, a color-coded string of beads representing the menstrual cycle, help a woman know which day of her cycle she is on, and identify whether she is on a day when she is likely to get pregnant.

The efficacy rates of the SDM are comparable to those of male condoms and better than those of other barrier methods. In an efficacy trial, 478 women from five sites in Bolivia, Peru, and the Philippines were followed for up to 13 cycles of method use. The pregnancy rate was only 4.8 with correct use.[2]
SDM introduction studies were conducted in the Philippines, India, Bolivia, Peru, El Salvador, Honduras, Guatemala, Ecuador, Rwanda, and Benin. They have demonstrated that providers can be trained in three to ten hours, depending on their educational level, as well as their experience and competency in family planning counseling. Most clients can learn the method in a single visit – usually around 30 minutes. A follow-up visit ensures higher quality of care.

Objective

This study aimed to test the effects of scaling-up interventions to insert SDM in service delivery systems and make communities aware of it as a contraceptive option. The objectives relevant to this presentation are the following:

Objective 1:	Test the effects on provider behavior of scaling-up SDM in service delivery systems
Objective 2:	Test the effects on client behavior of scaling-up SDM in service delivery systems
Objective 3:	Test the effects on community perceptions, attitudes, and behaviors of expanding SDM as a family planning option in targeted communities

Certain research questions related to the objectives were developed.

- Will providers adequately offer the SDM under typical service delivery circumstances? That is, will they present SDM with enough detail to attract users and will they offer acceptors all the information needed to use the method effectively? The introduction studies have shown adequate

[1] Wilcox AJ, Weinberg CR, Baird DD. Timing of sexual intercourse in relation to ovulation: Effects on the probability of conception, survival of the pregnancy, and sex of the baby. *New England Journal of Medicine* 1995; 333: 1,517-1,521; Wilcox AJ, Weinberg CR, Baird DD. Post-ovulatory ageing of the human oocyte and embryo failure. *Human Reproduction* 1998; 13: 394-397.

[2] Arévalo M, Jennings V, Sinai I. Efficacy of a new method of family planning: the Standard Days Method. *Contraception*, 2002; 65: 333-338.

provider management of SDM when they are under observation, i.e., under atypical circumstances.

- Will providers neutrally present the SDM along with established family planning methods as they counsel clients? This is an important issue, because SDM might displace more effective methods if providers have a positive bias, and use of SDM may be very low if providers have a negative bias. The introduction studies focused on provider management of the SDM with a research approach that was non-comparative. The need remains to show that providers will present SDM to clients in an unbiased manner.

- Will the total number of new family planning users increase in service delivery systems? The pilot studies showed that SDM was attracting people who previously had not used family planning. If this is replicated when the method is scaled-up, an increase in the total number of family planning users at the facilities can be expected.

- Will awareness of the SDM as an option increase among married women of reproductive age (MWRA)? Word-of-mouth from satisfied users as well as focused IEC efforts in communities can be expected to increase awareness of the method among MWRA in the community at large, yet this hypothesis has not been tested. Community awareness is the first step to sustained behavior change.

- Will the prevalence of SDM use significantly increase at the community level? In rural villages in Uttar Pradesh, India, the SDM prevalence increased from zero to about 7 percent on the basis of a limited intervention in a delivery system. Will expanded interventions in delivery systems and communities produce similar or improved results?

- Will the prevalence of family planning significantly increase at the community level? This can be expected if SDM attracts women who have never used family planning or discontinued using it in the past.

Design

A non equivalent control group with pretest and post test design was implemented at the India site; a non equivalent control quasi experiment design was implemented at the Peru and Rwanda sites.

Intervention

The Standard Days Method was integrated into existing service delivery programs of organizations already working at the sites. To achieve this, service providers were trained in how to offer and provide the SDM and updated in how to offer and provide other family planning methods. IEC activities were carried out in the communities. Service providers offered and provided the SDM as part of their regular work activities.

Control Group

Control group providers in India and Peru were offered training in the SDM after the post-test community survey was completed. In Rwanda, the MOH requested that the control group be able to offer the SDM sooner; providers in the control group were trained following the second round of mystery client visits.

Data Collection

To evaluate quality of service delivery and measure impact of introducing the method into services, the following techniques were used to collect data:

- Community surveys
- observation of providers' work
- collection of service statistics

Community Surveys

Baseline (in India and Peru sites) and endline (India, Peru and Rwanda) community surveys of MWRA and men were conducted. Information collected included general demographic data, socioeconomic information, reproductive history, family planning history, and attitudes towards family planning. Users of the SDM were asked additional questions regarding method use.

Observation of Providers

Trained observers ("simulated clients") visited facilities and requested family planning services. They enacted standardized profiles. After the visit to the facility, the "client" completed an assessment checklist.

Service Statistics

Trained personnel visited facilities where the SDM was offered and collected site service statistics, including numbers of clients who had received the SDM and other family planning methods in the past month.

Results

According to service statistics, SDM usage in all three countries gradually increased over time. In additiol, the majority of SDM users were new family planning users. In Rwanda and Peru, the percent of women who had not used a family planning method in the past two months was 61% and 96% respectively. In India, 87% of SDM users had never used a family planning method.
In analyzing the impact of introducing the SDM on method mix (comparing average number of birth-spacing method users (minus the SDM) from the quarter immediately prior to the intervention with the quarter one year later), we found a statistically significant increase in FP users in the India intervention site, but not in the India control site, as expected. In Rwanda, we found a statistically significant increase in both the intervention sites and the control sites. This is due largely to the small size of the country and the contamination of the control site with trained personnel from elsewhere in the country. In Peru, we found no statistically significant increase in either the intervention or control site, even though the number of new users did increase slightly. This is to be expected in such a high-prevalence context.

Analysis of the community survey is on-going, with data from the women's survey in India fully analyzed. Looking only at the intervention site, we found that 15% of women spontaneously mentioned having heard of the SDM and 43.8% had heard of it when probed, or a total of nearly 59% demonstrating knowledge of the SDM. This is a large increase over a period of two years, having started at nearly zero knowledge in the community. Of those who had heard of the method, 10% had ever used the SDM and 5% were currently using the method.

In Rwanda, we found that approximately 38.6% of survey respondents (men and women) spontaneously mentioned having heard of the SDM and 30% mentioned it when probed, for a total of 69%. Acceptability of the method was high among both men and women, at 83.5% and 78.5% respectively.

Simulated client visits in all three countries revealed interesting findings regarding quality of care. Simulated clients in all sites registered the time at which the consultation started and the time at which it ended. Session length varied widely across countries, with an average counseling time ranging from 10 minutes in India to 43 minutes in Rwanda. Peru and Rwanda exhibited much longer consultations than India.

The simulated clients used checklists with nine items to measure providers' interpersonal relations with clients including whether or not counseling was individual or interrupted, and whether or not providers treated clients amicably and with respect. Providers achieved high levels of interpersonal relations in Peru and Rwanda and moderately high in India.

The simulated client checklist also contained 56 information-exchange items that tapped areas related to needs assessment, eligibility criteria and method use instructions. Average results (out of a possible 56) were 23 for India, 29 for Peru and 39 for Rwanda.

In Rwanda, we found that dual protection was discussed more frequently in the intervention sites (average of 42%) than in the control sites (18%); data from other countries is forthcoming.

Discussion

Although analysis from this study is still ongoing, preliminary results support experiences from SDM introduction in several other countries in Africa, including Benin, Burkina Faso, DR Congo, Madagascar, Senegal and Zambia. These combined experiences indicate that the SDM largely attracts new users to family planning, that it can be easily and effectively used by clients and taught by providers, that it is acceptable to clients and that it increases couple communication. It appears that in the African context, the SDM can contribute to efforts to increase contraceptive prevalence, encourage usage of birth-spacing methods, and reposition family planning.