A Strategic Approach to Standard Days Method® Introduction: Expanding Availability and Use of FAM

EXECUTIVE SUMMARY

FINAL STUDY REPORT
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Executive Summary

Despite their efficacy and safety, the availability and use of fertility awareness-based family planning methods (FAM) are low in Title X clinics. The purpose of this project was to test whether integrating the **Standard Days Method® (SDM)**, a FAM that has proven to be both feasible for programs to offer and appealing to providers and clients, into Title X family planning (FP) services would increase use of FAM.

Specifically, this study (1) identified factors which constrain and facilitate FAM availability and use; (2) developed and tested a process to introduce SDM in FP clinics within a framework of expanded choice; and (3) assessed acceptance, correct use and satisfaction among SDM users. It was conducted by Georgetown University's Institute for Reproductive Health (IRH) in partnership with Cardea Services, JSI Research & Training Institute, Inc., and six Title X health centers.

The World Health Organization's Strategic Approach to contraceptive introduction was used both to guide the research and to develop an intervention that had potential for success. This approach calls for the integration process to be need-based and participatory and defines a three-phased framework for introducing a new family planning method: Phase 1: needs assessment; Phase 2; method integration and evaluation; and Phase 3: use of research results for policy and planning. The figure below summarizes the data collection elements of the study as they relate to program activities in the three phases.

Data collection and program activities

	Phase 1 Needs assessment		Phase 2 SDM integration and evaluation				Phase 3
Data elements	Pre SDM integration			Process evaluation		Outcome evaluation	Post integration
Site assessment	√	Tailor SDM integration activities based on needs assessment results	Fully integrate SDM into existing services in participating clinics		Modify integration activities based on results of fidelity research		Use of research results for policy and planning
Provider & staff interviews	√					√	
Client focus groups	√						
Simulated clients				√			
Waiting room questionnaire	√						
Client follow up						√	
Service statistics	→					→	

Needs assessment (Phase 1)

Prior to SDM integration, we assessed potential clients' knowledge, needs, and desire for FAM; provider knowledge, skills, attitudes and practices regarding FAM; service delivery systems and outreach activities in the selected clinics to determine how FAM is integrated into the services they offer; individual and institutional barriers that may hinder SDM uptake and use; and opportunities and challenges to adding SDM to the method mix. The needs assessment consisted of the examination of service statistics from the previous year, a site assessment to determine how SDM would fit into clinic systems, interviews with clinic staff, focus groups with potential clients, and waiting room questionnaires.

The results of the needs assessment activities suggested that SDM integration would be feasible at all clinics and accepted by providers and clients. Because FAM was not routinely offered at most study clinics prior to SDM integration, service statistics from the prior year counted only two FAM users reported by the participating clinics. Users were likely underreported, however.

From a systems perspective, discussions with clinic managers as part of a site assessment indicated that there would be no barriers to method integration that could not be resolved with minimal effort for the purposes of the study. However, procurement of CycleBeads®, the visual tool used by most SDM users to track the menstrual cycle, likely would be a challenge in the future as the tool was not on insurance formularies or included in government-sponsored family planning reimbursement programs.

Staff (n=37) from the participating clinics were in favor of expanding options for their clients and open to learning about and offering SDM. While there was some skepticism about the effectiveness of FAM in general among staff, there was also considerable enthusiasm about the ability of SDM to better meet the needs of those clients seeking a non-hormonal or natural method.

Community-based focus group discussions (nine discussions were held with a total of 64 participants) suggested that there was potential demand for a new method – particularly, for a method with no hormones or side effects and one that involved men – among communities served by the clinics. SDM would not meet the needs of all women – for example, those who desired a highly effective (99%+) method or whose partners were not amenable to using such a method. Nevertheless, these results confirmed that SDM integration would be appropriate for and would meet the needs of some women seeking a non-hormonal method.

The waiting room questionnaires (n=594) implemented as part of the needs assessment phase revealed lower satisfaction levels among users of barrier and traditional (such as rhythm and withdrawal) methods compared to users of other methods, suggesting that there were clients who could be better served by an additional non-hormonal method option. The mixed responses to the

question of when a woman is fertile by focus group participants and respondents to the waiting room questionnaires suggested a need for education on fertility awareness, for which CycleBeads would be a useful tool. However, lack of understanding of fertility could cause some potential clients to doubt the effectiveness of the method.

SDM integration (Phase 2)

Utilizing the results of the needs assessment, Cardea, JSI, and IRH worked with the service delivery agencies to integrate SDM into family planning services. The integration process included three components: (1) integration into clinic systems and establishment of method-related protocols; (2) staff training and support, including provision of SDM counseling aids; and (3) awareness-raising and outreach activities. Due to budget constraints, outreach activities were limited to low-cost efforts including presence at health fairs, community visits by outreach workers, and posting flyers around town.

Once SDM was integrated into clinic services, the fidelity of integration activities was tested to ensure that activities were correctly implemented and to gather information for the clinics to improve their services. We used simulated clients to gauge provider compliance and competence in SDM counseling at least three months after providers were trained in offering SDM.

Simulated client visits revealed strengths and weaknesses pertaining to SDM counseling. A main strength was that the majority of simulated clients received good information on how to use CycleBeads. The main weakness was that some providers did not adequately screen the client, or did not respond appropriately upon hearing the client's response to screening questions. The results of the simulated client visits were shared with each clinic and used to improve services.

Evaluation findings

To evaluate the effect of SDM integration, service statistics were collected each month to evaluate whether SDM integration resulted in an increase in the number of FAM users at each clinic. Post-integration staff interviews were conducted to evaluate provider perspectives following SDM integration and identify barriers to offering FAM. Finally, interviews with SDM clients were conducted to understand method use patterns, continuation, and satisfaction.

Service statistics: During the study, participating clinics reported a total of 198 SDM users, whereas during the year prior to SDM integration, the total number of documented FAM users at all participating study clinics combined was two. This made it clear that the number of FAM users increased after SDM integration.

Staff interviews: A total of 25 clinicians, nurses, medical assistants, and counselors from participating clinics were interviewed about a year after having been trained on SDM and CycleBeads. Some 62.5% said they discussed SDM with clients at least once per week. All of the staff members interviewed stated that they found it easy (either very easy or somewhat easy) to teach women how to use CycleBeads. Staff members generally said that SDM integration had no adverse effect on clinic flow.

All of them believed SDM was effective enough to offer as a birth control method in their clinic and felt that their agency should continue to offer the method after the study was over. The most common reasons staff members gave as to why it was important to offer a FAM such as SDM included the need to offer a wide range of options; the need to provide non-hormonal options for women who desired them; and the need to have a method for women whose religious beliefs left them with few options.

There were four main barriers cited by staff members regarding offering SDM: (1) staff forgetting to offer it because it had not yet been ingrained in them; (2) client preference for other methods; (3) clients not meeting the eligibility criteria; and (4) outreach workers' inability to dispense the method during community talks without a nurse present.

Staff at participating study clinics also identified barriers faced by clients that made it difficult for these clients to choose SDM as their family planning method. The four key barriers cited by staff members are: (1) the client did not meet eligibility criteria; (2) lack of transportation to the clinic, particularly by women in rural areas; (3) lack of confidence in the method or desire for a more effective method, and (4) lack of awareness that the method existed and was available at these clinics. To raise awareness of the method, staff members suggested mass media communications such as television and enhanced community outreach efforts.

Client follow up: Clients who chose SDM were invited to participate in the study by clinic staff immediately after receiving counseling. For clients who agreed to participate, study staff followed them for up to one year of method use, interviewing them at admission (41 clients), then three months (21 clients), six months (12 clients), and 12 months (8 clients) after admission.

Of the 41 clients reached upon admission, 36 were using SDM to prevent pregnancy and met the eligibility criteria for method use. The most common reason for choosing the method, mentioned by 75% of respondents, is that it was non-hormonal with no side effects. Some 93% of respondents said they heard about SDM from the health center.

Of the 21 clients reached after three months, 15 were still using SDM to prevent pregnancy. At six months, 12 clients were reached for interviews, and 10 were still using it to prevent pregnancy. At twelve months, eight clients were reached for interviews, and six were still using SDM to prevent

pregnancy. Reasons for discontinuation included out-of-range menstrual cycles, pregnancy (intended or unintended), end of relationship, and desire to use an IUD.

While all continuing users reported correct knowledge of the meaning of the red, brown, and white beads on CycleBeads, about half of users at three months reported being confused about how to use CycleBeads to track their cycle length each month to ensure that their cycles were not too short or too long to use the method. All users reported being either satisfied or very satisfied with SDM, and nearly all said SDM was easy to use. Some stated that their relationship with their partner had changed for the better since they began using SDM; the rest reported no change.

Because of the small numbers of clients interviewed, these results are informative but not generalizable.

Effect of SDM integration on number of FAM users

While SDM integration increased the number of FAM users at the participating clinics, the overall number of FAM users remained low with respect to the total number of female family planning clients. This was largely due to a lack of awareness among the populations served by the study sites about what CycleBeads were and their availability at the clinics. It was also due to staff forgetting to offer it and the absence of the method from multi-method posters or brochures used as counseling guides.

It became clear that if SDM was integrated at higher levels, including organization-wide (which could have meant method integration into multi-method posters, informational brochures, and counseling guides) and state-wide (which could have impacted the priority given to the method, particularly by managers and clinicians) – the integration process likely would have had greater impact.

Overcoming barriers to offering FAM

Prior to SDM integration, only clinicians were trained to discuss FAM with clients. However, the integration process (specifically, SDM training) enabled non-clinical staff – i.e., medical assistants, counselors, and health educators – to counsel clients on FAM, specifically SDM. However, integration of SDM with CycleBeads into clinic service delivery did not address a major barrier for FAM availability: that many people who needed the method were not reached, for reasons including lack of awareness of the method and lack of transportation to the clinic.

Use of research for policy and planning (Phase 3)

Study staff have engaged in efforts to disseminate and utilize study findings, including presentations at various national conferences. We have developed and are disseminating informational products based on project experience that will assist programs who wish to introduce SDM into their family planning services, including the *CycleBeads® Integration Guide: A Toolkit for Family Planning Programs* (available at http://www.CycleBeadsToolkit.com) and videos that demonstrate counseling scenes that can be used for provider training. Dissemination of these informational materials and study results is ongoing, and opportunities for in-person and online skills sharing and capacity building are being pursued.

Conclusions and recommendations for scale-up

This study demonstrated that SDM can be successfully introduced into family planning service delivery at Title X clinics, from reproductive-health-focused organizations to facilities providing the full range of primary care services. The number of FAM users increased dramatically due to SDM integration. Managers perceived that integrating the method into existing clinic-based systems was relatively simple and straightforward, and providers found that counseling on the method fit within the clinic flow.

Most clients chose the method because it was natural with no side effects and were able to use it successfully and satisfactorily. Staff of service delivery agencies perceived that offering SDM added value to their services because it enabled them to provide more options for their clients and to better meet the needs of clients seeking a non-hormonal method. Health center staff found CycleBeads easy to teach, and clients found the method easy to use.

Larger-scale integration – for example, at the organizational, state, and/or national level – will be required to meet client demand for a method such as this and to reach more women with information and services. Future, larger-scale integration efforts should take the following into consideration:

Utilize mass media campaigns to raise awareness of SDM and CycleBeads among potential clients. Raising awareness of the method through media such as newspapers, magazines, radio, television, or the internet, in a context of informed choice, would increase client knowledge of the method so that clients do not need to rely on the health center as their primary source of information.

Integrate SDM into multi-method counseling materials used by staff. Future integration projects should revise multi-method counseling aids in order to ensure that staff who rely on these

materials do not neglect to mention SDM to clients who may be interested. In addition, managers should remind staff to make the method a regular part of their counseling routines.

Include CycleBeads in reimbursement programs. For this study, CycleBeads were provided by IRH. To ensure that agencies can access the method and that method cost does not make it prohibitive for low-income clients, CycleBeads must be included in reimbursement programs such as California's Family PACT.

Find ways to reach rural areas with services so that lack of transportation to the clinic is not a barrier to access. This is likely an issue for all methods, not only SDM. However, unlike many clinical methods, SDM is an education-based method used with a simple visual tool (CycleBeads) that can easily be offered by non-clinical staff. Therefore, it is well-suited for distribution by outreach workers and *promotoras*.

In summary, this experience suggests that it is feasible and beneficial to offer SDM in Title X clinics. Integration of this method enables clinics to offer a simple fertility awareness-based method and therefore to better achieve their mission of offering a wide range of options to meet their patients' needs. However, sustainable, widespread integration of SDM in the United States likely will not occur until the method is included in state and national family planning norms and until the broader family planning community takes action to ensure that this method option is accessible to all.