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Research Brief

The Standard Days Method in Kenya's Ijara District: Final Results and Implications for Programs

KeyPoints

- The Standard Days Method™ (SDM) increases contraceptive prevalence, because it is an attractive option for clients who have not adopted other modern family planning (FP) methods.
- The SDM addresses an unmet FP need, because it is acceptable to clients who are concerned about side effects and to those who comply with religious and cultural dictates that prohibit other methods. However, the use of SDM faces challenges, such as limited availability of the CycleBeads™, lack of awareness of the method, and limited communication between men and women on FP and sexual relations.
- Mobilizing respected community members, providing visual aids and job aids for clinics, ensuring an adequate supply of the tracking tools to support compliance, and training community health workers (CHWs) will help to expand the use of SDM in the pilot region, as well as other regions where scale-up is planned.

Background and scope

Fertility awareness-based methods (FAM) rely on a woman's understanding of when she is most likely to become pregnant during her menstrual cycle. Practicing FAM means that a woman avoids sex or uses a barrier method during her fertile period. The Standard Days Method™ (SDM), developed by researchers at Georgetown University, is one FAM. When practiced perfectly, the SDM is more than 95 percent effective at preventing unwanted pregnancy without the side effects sometimes experienced with hormonal methods.

The SDM is a fairly new, easy-to-use FAM that overcomes many social, cultural, and religious barriers to FP. For women who have regular, 26-to-32-day menstrual cycles and are thus eligible to use this method, a color-coded string of beads, called CycleBeads™, is helpful. Using the beads, a woman can track her cycle and anticipate when pregnancy is most likely to occur (cycle days 8 through 19). To prevent pregnancy during this time, a couple can choose either to abstain from sex or use a barrier method.

FAM are not common in Kenya—6.3 percent of married women report using periodic abstinence, and 0.6 percent report using withdrawal (Kenya Demographic and Health Survey, or KDHS, 2003). To date, modern FP methods have failed to meet women's contraceptive needs in Kenya. Nearly 25 percent of women there have an unmet need for FP. One-third of those surveyed in 2003 who had discontinued use of modern FP methods cited social and cultural barriers. Forty percent of those who had never used modern FP methods attributed their decisions to these same impediments (KDHS, 2003).

Kenya's North Eastern Province (NEP) has a contraceptive uptake rate of 4 percent and a total fertility rate of 5.9 (KDHS, 2008). Here, social and cultural traditions (i.e., interpretations of Islam and/or some Somali cultural practices) often influence reproductive behavior.

In 2008, a situation analysis was conducted to assess the acceptability of introducing the SDM into the national FP method mix in Kenya. The SDM proved acceptable to many, and especially to respondents in the NEP. These results led to the implementation of a pilot project to introduce the method in the Ijara district in the NEP. This project was funded by the U.S. Agency for International Development (USAID) and implemented by the AIDS, Population, and Health Integrated Assistance Project (APHIA) II NEP, with support from Kenya's Division of Reproductive Health (DRH), Family Health International (FHI), and Georgetown University's Institute for Reproductive Health (IRH).

Purpose and methodology

The APHIA II NEP project partners chose to focus on Ijara because the situation analysis showed that, among districts in Kenya with the lowest contraceptive prevalence, Ijara was the most remote. Ijara's location and low FP uptake made it an ideal location to introduce a new method that was natural, easy to use, and required minimal clinic visits—the CycleBeads™.

The project partners wanted to determine the method's acceptability, discover whether new SDM users had practiced alternative FP methods in the past, and identify the reasons why women switched to the SDM. They also sought to document the experiences and recommendations of providers who offer the SDM.

Before initiating the pilot, the APHIA II NEP partners educated religious leaders in Ijara about the SDM and the concept of healthy birth spacing. They also guided the leaders to recognize that FP does not conflict with religious teachings. Subsequently, these leaders encouraged their communities to view FP favorably.

Seven providers from seven health facilities in Ijara were trained to provide SDM services and asked to fill out a questionnaire for each client who agreed to use the method. Demographic information and data on past FP use were

collected from responses to these questionnaires between January and June 2009. In April 2009, researchers conducted face-to-face interviews with service providers to record their experiences and opinions about providing the service.

Results

Between January and June 2009, 254 clients of seven health facilities in Ijara accepted the SDM and were given CycleBeads™. Of this group, most were Muslim (95 percent), female (97 percent), and married (97 percent). Their average fertility rate was 4.3, and their average age was 27 years old. Most (93 percent) were new to the use of a modern method.

When the SDM acceptors were asked to state their reasons for choosing the method, the top four reasons given were, "it doesn't affect health" (42 percent), "it has no side effects" (38 percent), "religious reasons" (33 percent), and "it is easy to learn/use" (31 percent). SDM acceptors were most likely to have learned about CycleBeads™ from their health providers (91 percent), with a small proportion having received this information from their husbands (4 percent).

Only 16 SDM acceptors reported that they had been using another FP method and wished to switch to the SDM. Among these, seven said that they were switching because their former method had undesirable side effects; two said that the method they had practiced previously was difficult to use. One person said that her former method affected her health, and another said that hers was against her religion.

Most providers had positive attitudes towards the SDM and felt equipped to offer the method to their clients. However, at a providers' review meeting held four months after the initial training, some variability in providers' skills and knowledge was observed. Also, it was noted that the NEP has a shortage of professionally trained service providers. Community health workers (CHWs), who had not been trained to offer the SDM, run many facilities there. It was recommended that these CHWs be trained to offer the SDM.

Providers reported that, compared to other FP methods, the SDM was acceptable to most clients. They mentioned many positive attributes of the SDM, emphasizing that it is natural and non-hormonal. These qualities make it suitable for clients with conditions that rule out hormonal methods. Also, providers stated that the SDM is culturally and religiously acceptable (the CycleBeads™ resemble beads used during prayer); that the method is simple to use and easy to comply with, as it is similar to a calendar-based method that is commonly used; and that the beads have an attractive color and packaging.

Providers reported facing challenges during SDM service provision, such as language barriers, general opposition to modern FP methods, limited time to explain the SDM to clients, a limited supply of the CycleBeads™, lack of awareness of the method among community members, and a lack of involvement by male partners in managing the method. The lack of male involvement, specifically the unwillingness of men and women to discuss the SDM, is particularly problematic for this method, because it requires partners to cooperate.

Conclusions

This introduction of the SDM in Kenya's Ijara district attracted new users of modern FP methods. Few clients switched to SDM from another method. Providers and clients had positive opinions of the method. However, as the project progressed, some gaps in knowledge were observed among the trained service providers, and concerns emerged regarding adequate commodity supply, the lack of male involvement in managing the method, and language barriers.

Based on their experiences, providers believed that the SDM could be scaled up in other districts in the province using the lessons learned from the Ijara pilot. Providers cautioned that successful scale-up would depend on adequate community sensitization, equipping providers with appropriate supplies of job aids and client education materials, supplying enough CycleBeads™ to meet demand, and training providers and backing them up with supportive supervision.

Implications

For successful scale-up of the SDM in other districts, program managers should take the following steps:

- Mobilize community leaders to promote awareness and knowledge of the advantages of birth spacing (in general) and the SDM (in particular). Because the SDM involves participation by both partners, a scale-up program must involve men and women equally.
- Ensure the availability of visual aids and educational materials in health facilities, to prompt clients to ask about the method. Equip providers with job aids to help them explain the SDM.
- Give providers regular on-the-job training and supportive supervision.
- Ensure that supplies of CycleBeads™ are adequate to meet demand, because demand will grow as scale-up progresses.
- Involve CHWs, because they speak the local language, may be more accepted by the community, and are already providing services in some health facilities. Give them adequate training and supportive supervision.

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