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COMMENTARY

The role of the Standard Days Method in modern family planning services in developing countries

Rebecka I. Lundgren*, Mihira V. Karra† and Eileen A. Yam‡

*Institute for Reproductive Health, Georgetown University, Washington, DC, USA, †Division of Research, Technology & Utilization, Office of Population and Reproductive Health, United States Agency for International Development, Washington, DC and ‡Department of Population, Family and Reproductive Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland, USA

ABSTRACT **Background** The mere availability of family planning (FP) services is not sufficient to improve reproductive health; services must also be of adequate quality. The introduction of new contraceptive methods is a means of improving quality of care. The Standard Days Method (SDM) is a new fertility-awareness-based contraceptive method that has been successfully added to reproductive health care services around the world.

Content Framed by the Bruce-Jain quality-of-care paradigm, this paper describes how the introduction of SDM in developing country settings can improve the six elements of quality while contributing to the intrinsic variety of available methods. SDM meets the needs of women and couples who opt not to use other modern methods. SDM providers are sensitised to the potential of fertility-awareness-based contraception as an appropriate choice for these clients. SDM requires the involvement of both partners and thus offers a natural entry point for providers to further explore partner communication, intimate partner violence, condoms, and HIV/STIs.

Conclusion SDM introduction broadens the range of FP methods available to couples in developing countries. SDM counselling presents an opportunity for FP providers to discuss important interpersonal and reproductive health issues with potential users.

KEYWORDS Quality of care; Standard Days Method; Natural family planning; Fertility-awareness-based family planning

INTRODUCTION

The introduction of new contraceptive methods in service delivery settings is widely regarded as a means of improving quality of family planning (FP) care. Beginning with the debut of the oral contraceptive in the 1960s, a gradual expansion of contraceptive choice has taken place, thanks to the introduction of an array of reversible options such as the intrauterine device

Correspondence: Rebecka Lundgren, MPH, Director of Research, Institute for Reproductive Health, Georgetown University, 4301 Connecticut Avenue NW, Suite 310, Washington, DC 20008, USA. Tel: + 1 202 687 1392. Fax: + 1 202 537 7450. E-mail: lundgrer@georgetown.edu

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(IUD), subdermal implants, and injectables. Every contraceptive option has different characteristics in terms of safety, side effects, permanence, protection against sexually transmitted infections (STIs, including HIV), or mode of administration. For instance, the introduction of no-scalpel vasectomy necessarily demands an assessment of the surgical capacity of a facility and its personnel. The Standard Days Method® (SDM), a new fertility awareness-based method, requires providers to understand a woman's fertile cycle, as well as to address relationship dynamics between the man and the woman. This paper describes how the introduction of SDM in a variety of service delivery settings expanded the range of contraceptive options in developing countries, and encouraged providers to consider natural FP as an appropriate choice for certain clients.

FERTILITY-AWARENESS-BASED FAMILY PLANNING AND THE SDM

Since the early 1900s, women have used a variety of fertility-awareness devices and guidelines to abstain from intercourse on days when they are likely to become pregnant. Some natural FP strategies entail monitoring biological symptoms such as cervical secretions and basal body temperature. For example, the Billings ovulation method (BOM) requires that women monitor and distinguish between different cervical secretions to detect fertile days; the TwoDay Method® (TDM) is based on observing cervical secretions, though without the requirement to distinguish between different types of secretions; and the symptothermal method (STM) requires monitoring both cervical secretions and basal body temperature. Reported typical-use efficacy of these methods ranges from 19.6 per 100 woman-years for the BOM to less than 2.0 pregnancies per 100 woman-years for the STM, with TDM efficacy at 13.7 per 100 woman-years. However, there were pronounced differences in the country contexts and socioeconomic status of study populations in these efficacy trials, so cross-method comparisons should be interpreted with caution[1,2].

In addition to natural FP methods that rely on observing physiological changes, other fertility awareness-based options consist of detecting the fertile window by monitoring the length of the menstrual cycle. SDM is a simple, effective, fertility awareness-based FP method developed in 2001 by the Institute for Reproductive Health (IRH) at Georgetown University. SDM requires avoiding unprotected intercourse during a fertile 12-day window of time in the middle of a woman's cycle (days 8–19). It is most appropriate for women with cycles that usually range from 26–32 days. To help couples monitor cycle length and identify fertile days, IRH also developed a mnemonic device (CycleBeads®) consisting of a strand of colour-coded beads that correspond to fertile and 'safe' days[3,4]. In contrast to the BOM, the STM, and the TDM, the length of the fertile window is fixed under the SDM; users do not need to rely on varying physiological symptoms to determine when they are fertile. A multi-country efficacy trial demonstrated that SDM failure rate is less than five pregnancies per 100 woman-years during the first year of perfect use, or 12 pregnancies per 100 woman-years with typical use[5]. A recent follow-up study found that in the second and third years of SDM use, typical-use failure rates drop to less than six per 100 woman-years[6].

SDM is a fertility awareness-based method characterised by its simplicity, scientific basis, and its widespread introduction in more than 30 countries, most prominently in the developing world. Currently included in the national FP norms in 16 countries, the SDM is recognised by the World Health Organisation as an evidence-based modern method, and CycleBeads can be procured along with other contraceptive methods through the Central Contraceptive Procurement Project of the US Agency for International Development (USAID). Compared to the BOM and STM, SDM is both easier to teach and to learn, requiring substantially less training time for providers, as well as a shorter amount of time before clients can use it autonomously. This makes it unique among natural methods, in that it can be offered in service delivery settings where client-provider interaction may be limited. However, unlike the BOM, STM, or TDM, SDM is only appropriate for women with regular menstrual cycles, which can preclude its use among postpartum women or young adolescents whose menstrual cycles have not yet stabilised. In addition, as is the case with any non-barrier contraception, the SDM does not protect users against sexually transmitted infections, including HIV, so it is intended to be a couple method, and is inappropriate for women who are not in monogamous relationships[7].

In the past decade, IRH has fielded SDM pilot studies in public sector facilities and in community settings in Latin America, sub-Saharan Africa, Asia, as well as

more recent pilots in the United States[8,9]. In addition, international and local organisations other than IRH have led efforts to introduce SDM in their programmes, as illustrated by Pathfinder International's recent SDM introduction in community-based service delivery settings in Ethiopia[10]. Although the previously described natural FP methods have been tested and introduced in various countries, to our knowledge, they have not been expanded widely in existing FP service delivery settings, as has SDM.

The purpose of this paper is to describe how SDM introduction can improve the quality of FP services in developing countries. Guided by the Bruce-Jain quality of care framework[11,12], we will present examples of how FP services benefited from SDM introduction. The findings and descriptions presented here are based primarily on reviews of published articles, internal project documents, and interviews with IRH staff.

FAMILY-PLANNING QUALITY OF CARE AND THE SDM

The Bruce-Jain quality of care framework is regarded as the main paradigmatic model for assessing the quality of international FP services[13]. The six elements of quality of care in the Bruce-Jain framework are:

- choice of contraceptive methods,
- information given to users,
- provider competence,
- interpersonal relations,
- re-contact and follow-up mechanisms, and
- appropriate constellation of services.

To discuss the role of SDM in modern FP services in an orderly fashion, we have structured this paper around these six elements of quality of care.

Choice of contraceptive methods

Throughout this discussion, it is important to bear in mind that, consistent with recommendations by Simmons and colleagues, SDM introduction activities are not exclusively focused on promoting SDM[14]. Rather, the overarching objective is to increase contraceptive choice by expanding the existing method mix. SDM provider trainings begin with a contraceptive technology update, which offers an overview of *all* available methods, including information on efficacy, side effects, and contraindications. It is not enough to merely add a new contraceptive to the mix; it is critical that the available methods meet the needs of potential users with different preferences or contraindications. SDM users have repeatedly cited their satisfaction in terms of its minimal cost, simplicity, naturalness, involvement of both partners, and, to a lesser extent, its compatibility with religious beliefs[8,15]. Irregular menstrual cycles are the only medical contraindication for using SDM, and among women who discontinue use of this method, one of the more commonly cited reasons is that their cycle lengths were outside of the required 26–32 day range[16]. In summary, SDM is appropriate for those who prefer non-hormonal and non-clinical birth control, who have regular menstrual cycles, who are at low risk of HIV/STI, and are able to use condoms or abstain from vaginal intercourse for 12 consecutive days each cycle.

Information given to users

A critical component of FP quality of care is the information given to potential users. This information should include contraindications, risks, and benefits of various methods, instruction on how to use the selected method, how to manage potential side effects, and what users can expect from service providers regarding advice, support, supply, and referral to other services[11,12]. When introducing SDM, provider trainings always include an overview of *all* methods, taking care to present the new method as *one of many* contraceptive options.

When clients select SDM, this method choice provides a natural entry point to further explore partner communication, sexuality, intimate partner violence, condom use, and HIV/STIs. Because SDM users must identify a strategy for managing the fertile days – one option being condom use – SDM counselling can seamlessly include discussion about supplementing SDM with periodic condom use, should a couple wish to have sex during the fertile period. In contrast, if a woman were a hormonal method user, a proposal to combine use with condoms would typically be framed as a means of protecting the woman from HIV, which providers are reluctant to do and may not be well received. When counselling about SDM, condoms can be discussed in a manner that weakens their sole association with HIV, emphasising their usefulness as contraceptives.

Furthermore, SDM presents a rare opportunity to explain the basic mechanisms involved in fertility and regulation of the menstrual cycle. This information is useful regardless of which method the client eventually adopts, and can also be helpful if the woman tries to become pregnant in the future. By teaching her to identify the days of the month when she is fertile, SDM counselling can help her better understand when she is most likely to get pregnant, heightening her awareness of the probability of pregnancy from unprotected sex.

Provider competence

Provider competence refers to their technical skills and capacity with regard to, for instance, asepsis and adherence to protocols of clinical contraceptive methods such as surgical sterilisation or the IUD. Although such technical skills do not apply to a natural method like SDM, providers who have undergone SDM training have increased awareness of women's fertility, which is important fundamental knowledge that likely improves providers' ability to counsel on all methods, as well as on the menstrual cycle generally. In fact, providers report that this increased ability to explain simply basic concepts of fertility helps them reassure their clients about the safety and efficacy of contraceptive methods generally, resulting in increased FP acceptance. In addition, because SDM requires the awareness and involvement of both partners, providers who counsel on the method develop the capacity to discuss relationship dynamics and partner communication, which is a valuable skill regardless of the contraceptive method in question.

Interpersonal relations

Interpersonal relations refer primarily to the client-provider dynamic. An important aspect of interpersonal relations in FP counselling is respect for the client's right to make an informed choice about which method is appropriate for him or her. When being trained on SDM, providers must overcome not only preconceived biases against fertility-awareness-based methods, but also a deeply rooted assumption that efficacy is the most valued characteristic of a FP method for everyone, regardless of where they are in the life course. For a variety of reasons, some women may feel most comfortable with a natural method, even if other, more effective modalities are available. Whereas, previously, providers in many developing countries felt they had little to offer to these women, SDM now presented an option that satisfied their need for scientific evidence that a natural method can have proven contraceptive efficacy, while also satisfying women's desire to use a non-hormonal, non-clinical FP method. The scientific basis of SDM can help to assure otherwise sceptical providers that fertility awareness-based methods can be an effective means of preventing pregnancy, and providers often report that SDM introduction made them more receptive to natural methods as an option for some women. This provider ability to maintain an objective openness to *all* available, effective methods is an indispensable element of quality client-provider relations.

In addition, simulated client studies conducted by IRH have demonstrated that providers trained on SDM were rated highly in terms of their 'interpersonal relations' in India, Peru, and Rwanda. These studies consisted of having trained volunteers pose as real clients who consulted providers who had undergone SDM training; each volunteer was given a user profile to enact, including marital status, childbearing desires, partner relationship dynamics, comfort with various methods, phase of the menstrual cycle, and specific method to be selected. As an indication of the high levels of courtesy exhibited by the providers, the proportion of simulated clients who felt that the provider treated them 'amiably' and 'respectfully' ranged from 75 to 100%[17].

Re-contact and follow-up mechanisms

To best promote continuity of use, it is critical to have follow-up mechanisms in place that allow providers and users to confirm correct use, address any concerns, and improve user satisfaction. The quality component is particularly relevant for methods that may carry a risk of side effects. Follow-up counselling sessions provide an opportunity to verify that SDM users are using CycleBeads properly, that the woman's menstrual cycles are still within the regular range, confirm that the couple is able to abstain from unprotected sex during the fertile days, and clarify and address any confusion or concerns. Because subsequent research determined that removing follow-up sessions did not lead to less correct SDM use, such follow-ups were deemed optional, which allows providers to treat

SDM services as they do other methods. In facilities where follow-up is routine for all methods, it also is required for SDM. However, if follow-up is not standard for other methods in a given facility, then there would be no required follow-up for SDM. In cases where follow-up is possible, it can be offered in the form of a counselling session after the first cycle to check cycle length, confirm correct use, and assess user satisfaction with SDM.

Appropriate constellation of services

FP services must be offered in a convenient, acceptable manner to women and their partners. Recognising that different settings warrant different strategies for contraceptive introduction, IRH has collaborated with a variety of local and international partners across sectors to introduce SDM through a wide range of venues and programmes. For example, in Guatemala, IRH and partners trained traditional birth attendants to provide FP counselling, including SDM. Community health workers in India provide SDM counselling in household visits. In Rwanda and Honduras, faith-based organisations have played a prominent role in offering natural FP methods compatible with religious teachings, in large part due to IRH's SDM introduction activities. In addition, given that SDM requires male participation for correct use, IRH and partners have made a concerted effort to encourage male involvement in birth spacing and contraception. For example, in an effort to reach men who would not otherwise participate in reproductive health activities, IRH worked with Project Concern International in El Salvador to introduce FP discussion groups into a water and sanitation project, whose participants were primarily male[18].

CONCLUSION

The introduction of *any* new contraceptive option can improve the quality of FP services, but we have sought to demonstrate that our experiences introducing SDM can address unmet client need, particularly in low-resource developing-country settings. As a couple strategy that requires management of fertile days, partner communication, consideration of HIV/STI risk, and a basic understanding of the menstrual cycle, SDM provides an opportunity for health services not only to increase the range of available FP options, but also to broaden the scope of FP counselling to cover other important issues.

Arguably one of the most significant quality improvements brought about by SDM introduction has been how the method sensitises providers to the reality that they cannot take a one-size-fits-all approach to FP counselling, and that each method suits the preferences and needs of a distinct user profile. For married women who place a premium on maximising efficacy and are comfortable with hormonal methods, but who do not wish to remember to take a pill each day, injectables may be an appropriate option. Tubal occlusion may be a good option for women who have completed their childbearing. In contrast, SDM could suit the needs of couples who prefer a natural method, whether due to discomfort with hormonal contraception, religious beliefs, financial considerations, or relationship dynamics. While other natural methods share these characteristics, they are not routinely offered by health and FP services. Previously, most providers had little awareness of scientifically proven methods that could accommodate such clients, but SDM has helped to fill this gap while simultaneously reinforcing the importance of client-centred contraceptive counselling.

In summary, ten years of experience with SDM have demonstrated the value of expanding the contraceptive method mix in a wide range of countries and service delivery settings. Previous research has documented the method's efficacy[12,13], described SDM users[15,18], and assessed the FP counselling given by providers trained on the SDM[17]. This paper adds a reflection on how and why SDM introduction can improve quality of care and the client-provider interaction.

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REFERENCES

1. Freundl G, Sivin I, Batár I. State-of-the-art of non-hormonal methods of contraception: IV. Natural family planning. *Eur J Contracept Reprod Health Care* 2010; 15:113–23.
2. Sinai I. Different methods for different needs: perception, behavior, and effectiveness. In Fehring RJ and Notare T, eds. *Human fertility: where faith and science meet. Proceedings of an interdisciplinary conference, August 11 & 12, 2006, Washington, DC*. Milwaukee: Marquette University Press 2006:157–68.
3. Gribble JN. The Standard Days Method of family planning: a response to Cairo. *Int Fam Plann Perspect* 2003; 29:188–91.
4. Jennings VH, Arevalo M, Kowal D. Fertility awareness-based methods. In Hatcher RA, Trussell J, Stewart F, *et al.*, eds. *Contraceptive technology*, 18th edn. New York: Ardent Media, Inc. 2004:317–29.
5. Arevalo M, Jennings V, Sinai I. Efficacy of a new method of family planning: the Standard Days Method. *Contraception* 2002;65:333–8.
6. Sinai I, Lundgren RI, Gribble JN. Continued use of the Standard Days Method [published online ahead of print 20 August 2011]. *J Fam Plann Reprod Health Care*. Accessed 13 February 2012 from: http://jfprhc.bmj.com/content/early/2011/08/20/jfprhc-2011-100097.abstract
7. Institute for Reproductive Health (IRH). *The Standard Days Method (SDM): a modern family planning method*. Washington, DC: Georgetown University 2010. Accessed 23 August 2011 from: http://www.irh.org/sites/default/files/FAM_Project_SDM_Modern_Method_Brief_0.pdf
8. Gribble JN, Lundgren RI, Velasquez C, *et al*. Being strategic about contraceptive introduction: the experience of the Standard Days Method. *Contraception* 2008; 77:147–54.
9. Institute for Reproductive Health (IRH). *A powerful framework for women: introducing the Standard Days Method to Muslim couples in Kinshasa*. Washington, DC: Georgetown University 2011.
10. Bekele B, Fantahun M. The Standard Days Method: an introduction to the arsenal of family planning method choice in Ethiopia [published online ahead of print 20 August 2011]. *J Fam Plann Reprod Health Care*. Accessed 13 February 2012 from: http://jfprhc.bmj.com/content/early/2011/08/20/jfprhc-2011-100116.abstract
11. Jain AK. Fertility reduction and the quality of family planning services. *Stud Fam Plann* 1989;20:1–16.
12. Bruce J. Fundamental elements of the quality of care: a simple framework. *Stud Fam Plann* 1990;21:61–91.
13. Creel LC, Sass JV, Yinger NV. Overview of quality of care in reproductive health: definitions and measurements of quality. *New Perspectives on Quality of Care: No. 1*. Washington, DC: Population Reference Bureau 2002.
14. Simmons R, Hall P, Diaz J, *et al*. The strategic approach to contraceptive introduction. *Stud Fam Plann* 1997; 28:79–94.
15. Institute for Reproductive Health (IRH). *Assessing the impact of scaling up the Standard Days Method in India, Peru, and Rwanda*. Washington, DC: Georgetown University 2008.
16. Blair C, Sinai I, Mukabatsinda M, *et al*. Introducing the Standard Days Method: expanding family planning options in Rwanda. *Afr J Reprod Health* 2007;11:60–8.
17. Leon FR, Lundgren R, Huapaya A, *et al*. Challenging the courtesy bias: interpretation of favorable clients' perceptions of family planning delivery. *Evaluation Rev* 2007;31:24–42.
18. Lundgren RI, Gribble JN, Greene ME, *et al*. Cultivating men's interest in family planning in rural El Salvador. *Stud Fam Plann* 2005;36:173–88.