

Assessing the Introduction of Standard Days Method® (SDM) into Family Planning Services in Selected Regions of Ghana

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IRH was awarded the 5-year Fertility Awareness-Based Methods (FAM) Project by the United States Agency for International Development (USAID) in September 2007. This 5-year project aims to increase access and use of FAM within a broad range of service delivery programs using systems-oriented scaling up approaches.

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Table of Contents

Acronyms.....	i
List of Tables & Figures.....	ii
Executive Summary.....	iii
Introduction.....	1
1.1. Background.....	1
1.1.1. Focus Region Health Project (Family Planning).....	2
1.2. Rationale.....	2
1.3. Objectives.....	3
1.3.1. Specific Objectives.....	3
Methodology.....	3
2.1. Study Design.....	3
2.2. Study Area.....	3
2.3. Study Population.....	4
2.4. Preparatory, Intervention, and Assessment Steps.....	4
2.5. Study Procedures.....	4
2.5.1. Recruitment and training of research staff.....	4
2.5.2. Data collection.....	5
2.5.3. Data analysis and reporting.....	5
2.5.4. Study limitations and field challenges.....	5
2.6. Ethical issues.....	6
Results and Discussion.....	7
3.1. Introduction.....	7
3.2. Background characteristics of SDM users.....	7
3.3. Competence level of SDM users.....	8
3.4. Client experience with SDM.....	8
3.5. Male involvement.....	10
3.6. Competence level of providers at offering SDM as a FP method.....	10
3.7. Introduction of SDM and effect on uptake of other contraceptive methods.....	11
3.8. SDM contribution to method mix in the three regions.....	13
3.9. Physical audit of FP commodities stock availability and absence of service.....	14
3.10. SDM sensitization and awareness raising activities.....	15
3.11. Provider training in SDM counseling.....	16
3.12. Qualitative Data.....	17
Conclusions and Recommendations.....	19
4.1. Conclusions.....	19
4.2. Recommendations.....	19
References.....	21
Appendices.....	21

Acronyms

AEE	Ajumako-Enyan-Essiam
CHN	Community Health Nurse
CHPS	Community-based Health Services and Planning
CHRPE	Committee for Human Research, Publications and Ethics
CSM	Contraceptive Social Marketing
DPHN	District Public Health Nurse
FHD	Family Health Division
FP	Family Planning
FPHP	Family Planning and Health Project
FRHP	Focus Region Health Project
GHANAPA	Ghana Population and AIDS Project
GHS	Ghana Health Service
GPRS	Ghana Poverty Reduction Strategy
HIV	Human-Immunodeficiency Virus
HSMTDP	Health Sector Medium-Term Development Plan
IEC	Information Education and Communication
IUD	Intra-uterine Device
KNUST	Kwame Nkrumah University of Science Technology
LEKMA	Ledzokuku-Krowor Municipal Assembly
MDGs	Millennium Development Goals
MSI	Marie Stopes International
NGOs	Non-Governmental Organizations
PPAG	Planned Parenthood Association of Ghana
SDM	Standard Days Method
SMS	School of Medical Sciences
STIs	Sexually Transmitted Infections
TFR	Total Fertility Rate
THLD	Twifo-Hemang-Lower Denkyira
USAID	United States Agency for International Development

List of Tables & Figures

Table 1..... 7
Table 2..... 8
Table 3a..... 9
Table 3b..... 10
Table 4..... 11
Table 5a..... 12
Table 5b..... 13
Table 6..... 14
Table 7..... 15
Table 8..... 16
Table 9..... 17

Figure 1..... 13
Figure 2..... 15

Executive Summary

Introduction

The Ghana Health Service (GHS), the United States Agency for International Development (USAID) and other health development partners have been interested in adding the Standard Days Method® (SDM) to family planning (FP) activities in Ghana. While natural FP methods are noted as such in the GHS family planning service norms, the GHS currently does not systematically include the SDM in its FP programs and CycleBeads® are not widely available in the country.

To expand FP options, the Georgetown University-Institute for Reproductive Health in collaboration with the GHS and the Focus Region Health Project (FRHP), and with funding from USAID-Ghana undertook a pilot to integrate the SDM into clinic and community FP services in six (6) districts in three (3) regions: Ledzokuku-Krowor Metropolitan Area (LEKMA) and Ayawaso sub-metropolitan area (Greater Accra), Ajumako-Eyan-Essiam and Twifo-Heman-Lower Denkyira (Central Region), Amenfi West and Juabeso (Western Region).

The pilot integration activities in health facilities across the six (6) districts, which began in February 2012 after the completion of training-of-trainer and district-level planning activities in late 2011, were designed to allow GHS and FRHP staff to gain experience and skills in offering the SDM as part of FP services and, assuming good results, to determine a way forward to expand SDM into FP services in other districts. By selecting a variety of districts and facilities, it was possible to explore the results further, to contribute to the discourse on expanding FP options in Ghana with the view to improving FP uptake.

Towards the end of 2012, IRH engaged the Kwame Nkrumah University of Science and Technology-School of Medical Sciences to undertake an assessment of the pilot integration effort and to answer the following questions:

1. What is the effect of adding SDM to family planning services?
2. What is the user discontinuation rate for SDM and what are the reasons?
3. Why do people choose SDM?
4. How do couples who use the SDM manage fertile days?

The assessment was in the adequacy category of assessments and hence did not have a control group.

Findings

Effect of adding SDM to family planning services: SDM contributed to the method mix; 6% of new users of family planning chose the CycleBeads®, and 94% of SDM users had never used a family planning method. Very few (6%) family planning users switched from other methods to SDM; the dislike for the other family planning methods and the fear of side effects were the major reasons for switching.

SDM discontinuation rate and reasons: The SDM discontinuation rate was very low (2%); partner dislike for the method and the desire to get pregnant were the main reasons for discontinuation.

Why people choose SDM: Family planning clients chose SDM because they desired a natural/non-chemical method (62%), feared the side effects of other family planning methods (31%), and were universally (98%) satisfied with their method choice.

How couples use SDM and manage fertile days: Male partners were involved mainly in the matters related to moving the ring; 64% reminded their female partners to move the ring while one-in-four moved the ring themselves. Even though some males were unhappy with the “long” abstinence period, condom was used in most cases to manage the fertile period.

Introduction

1.1. Background

The world is only a couple of years away from 2015, and the realization that majority of countries are not on track to achieving the Millennium Development Goals (MDGs) has important implications. The economic and health benefits of family planning are without doubt; improved access to family planning has the potential to reduce poverty and hunger, avert 32% of maternal deaths and almost 10% of childhood deaths, contribute significantly to women's empowerment, and assist to achieve universal primary education and environmental stability thus contribute significantly to addressing the MDGs.¹ Nearly 25% of married women in sub-Saharan Africa have an unmet need for family planning, and the use of modern contraceptives has plateaued in many developing countries, especially in Africa.²

In the Ghana National Population Policy of 1994, the nation seeks to increase the modern contraceptive prevalence rate to 28% by 2010 and to 50% by 2020.³ The Family Health Division (FHD) of the Ghana Health Service (GHS), which is responsible for family planning services, has prioritized increasing availability and appropriate utilization of family planning services.

Ghana was one of the first countries in sub-Saharan Africa to have a population policy. In 1967, the Planned Parenthood Association of Ghana (PPAG) was established, and in 1969, the Ghana National Family Planning Program was launched, giving rise to organized approaches to promoting family planning. Since 1969, the Government of Ghana has promoted family planning through a number of program initiatives: the Contraceptive Social Marketing (CSM) project (1987-1990), the Ghana Family Planning and Health Program (FPHP) (1990-1996) and, the Ghana Population and AIDS Project (GHANAPA) (1996-2000). Initially, these interventions were designed to increase demand and utilization of modern family planning methods through social marketing. The FPHP expanded the capacity of the public and private sectors to provide family planning services, supplies and information. It also addressed sexually transmitted infections (STIs) and HIV.⁴ The Ghana Poverty Reduction Strategy (GPRS) represents a comprehensive set of policies to support growth and poverty reduction over a three-year period (2002-2004). It represents the Government's aim to create wealth by transforming the nature of the economy to achieve growth, accelerated poverty reduction and the protection of the vulnerable and excluded within a decentralized, democratic environment, and repositioning Family Planning is mentioned in all the various programs of work of the Ghana Ministry of Health/Ghana Health Service for the past decade. The goal of the "Road map for repositioning family planning in Ghana" is to contribute to the realization of the Ghana Poverty Reduction Strategy (GPRS), the MDGs and other national socio-economic development objectives through improved FP uptake by 2010; the targets include a reduction in the Total Fertility Rate (TFR) to 3.0, unmet need 20% and a population growth rate of 2%.⁵ The Health Sector Medium-Term Development Plan (HSMTDP) 2010-2013, seeks to improve access to effective public health interventions that could lead to a 40% reduction in the FP gap.⁶

Health development partners and Non-Governmental Organizations (NGOs) continue to promote family planning through many avenues all over Ghana and there has been an increase in the variety of methods available. Since 1996, the injectable and the female condom have been introduced in both the private and public sectors; the female condom was re-launched in 2012. In recent times, the emphasis has been to expand access to permanent (mini-laparatomies and vasectomies) and long-term methods (intra-uterine devices and implants). This has increased the variety of methods and family planning choices available to the public. Special efforts have also been made in an attempt to reach special groups such as adolescents, young adults and men. At a contraceptive

prevalence rate of 23%, the proportion of maternal deaths in Ghana averted by contraceptive use is estimated at 36%.⁷

Many studies have investigated the factors that influence contraceptive use in many countries. The myriad of factors may be grouped into service-related, community/household/socially-related and personal factors. The community, household and individual decisions are influenced by fears of side-effects, myths and traditional beliefs about various contraceptive methods and wider social support for acceptance and use of contraceptives. Other factors involved in family planning choices include age, education level, place of residence, economic status, financial costs, status of women, provider bias and misinformation, and relationship issues among others.

A better understanding of how 'new' methods can contribute to and improve the method mix in Ghana may be one of the approaches to improving choice options, acceptability and ultimately, the contraceptive prevalence rate for the country.

1.1.1. Focus Region Health Project (Family Planning)

The USAID Focus Region Health Project (FRHP) included a component to improve Family Planning (FP) services in beneficiary communities. The Ghana Health Service (GHS), the United States Agency for International Development (USAID) and other health development partners have been interested in adding the Standard Days Method® (SDM) to FP activities in Ghana. While natural FP methods are noted as such in the GHS Family Planning service norms, the GHS currently does not systematically include the SDM in its FP programs and CycleBeads® are not widely available in the country. To expand FP options, the Georgetown University-Institute for Reproductive Health provided technical assistance to integrate the SDM into clinic and community FP services in six (6) districts in three (3) regions: Ledzokuku-Krowor Metropolitan Area (LEKMA) and Ayawaso sub-metropolitan area (Greater Accra), Ajumako-Eyan-Essiam and Twifo-Heman-Lower Denkyira (Central Region), Amenfi West and Juabeso (Western Region). The pilot integration activities in health facilities across the six (6) districts, which began in February 2012 after the completion of training-of-trainer and district-level planning activities in late 2011, were designed to allow GHS and FRHP staff to gain experience and skills in offering the SDM as part of FP services and, assuming good results, to determine a way forward to expand SDM into FP services in other districts. By selecting a variety of districts and facilities, it was possible to explore the results further, to contribute to the discourse on expanding FP options in Ghana with the view to improving FP uptake.

As part of the intervention, FRHP selected, trained and deployed family planning providers who were supplied with CycleBeads® and other necessary toolkits for SDM. During this phase, supervisors monitored participating health facilities to ensure good data capture on new users and awareness creation activities, and to guarantee that providers were providing correct counseling on SDM. In the first four (4) months of the intervention, monthly meetings were held with providers to ascertain policy and contextual issues.

For the purposes of this assessment, FRHP provided a list of the health facilities which were part of the SDM intervention. The Project facilitated contact between the study team and the Ghana Health Service; regional and zonal officers of FRHP prepared the ground for the assessment process.

1.2. Rationale

The inclusion of SDM as an introductory activity into the GHS-FP services was likely to be expanded if successful, and both the processes and outcomes were worth examining. Process questions

would be the provision of information about whether, and how to adjust the SDM introduction activities for the next phase of services expansion. Outcome questions would allow us to answer larger questions about the potential contribution of SDM to family planning programs, such as client and provider satisfaction in using/offering the SDM, the proportional contribution of new SDM users compared with new users of other FP methods, including whether the SDM displaces other FP methods, a concern raised by some stakeholders in Ghana.

1.3. Objectives

The main aim of this evaluation was to provide information about the integration of SDM into the GHS-FP and the potential contribution of SDM to family planning programs

1.3.1. Specific Objectives

1. To assess use of SDM as a family planning option in the Ghana Health Service setting
2. To determine the effect of SDM usage on the uptake of other Family Planning methods
3. To determine the competence level of providers in offering the SDM method
4. To determine the competence level of users in the use of SDM
5. To gather experience and suggestions of stakeholders involved in SDM introduction for scale up in other districts that want to add SDM to their FP services

Methodology

2.1. Study Design

A retrospective evaluation study design using a current cross-sectional approach was used to assess the implementation of the introduction of SDM into the FP program of Ghana. Evaluation studies seek to measure how well project/program activities have met expected objectives and/or the extent to which changes in outcomes are attributable to the project or intervention. It is important to note that the introduction of the SDM was to expand FP options. IRH provided technical assistance to integrate the SDM into clinic and community FP services in six districts and several sites in three (3) regions of Ghana.

Since SDM is a new method in Ghana, was not yet available in the participating sites, and providers had little or no prior experience if offering the SDM, we opted for a one-shot evaluation design with measurement taking place at one time only, about nine (9) months after the SDM had been introduced in all sites. Given the context, we assumed that the observed SDM uptake and reflections offered by providers and users would be due to the set of introduction activities associated with adding SDM to FP services. In addition, the selection of a wide range of districts in which to pilot SDM introduction would allow a certain confidence in the generalizability of the findings to other districts in Ghana since the MOH/GHS was interested in potentially expanding SDM services.

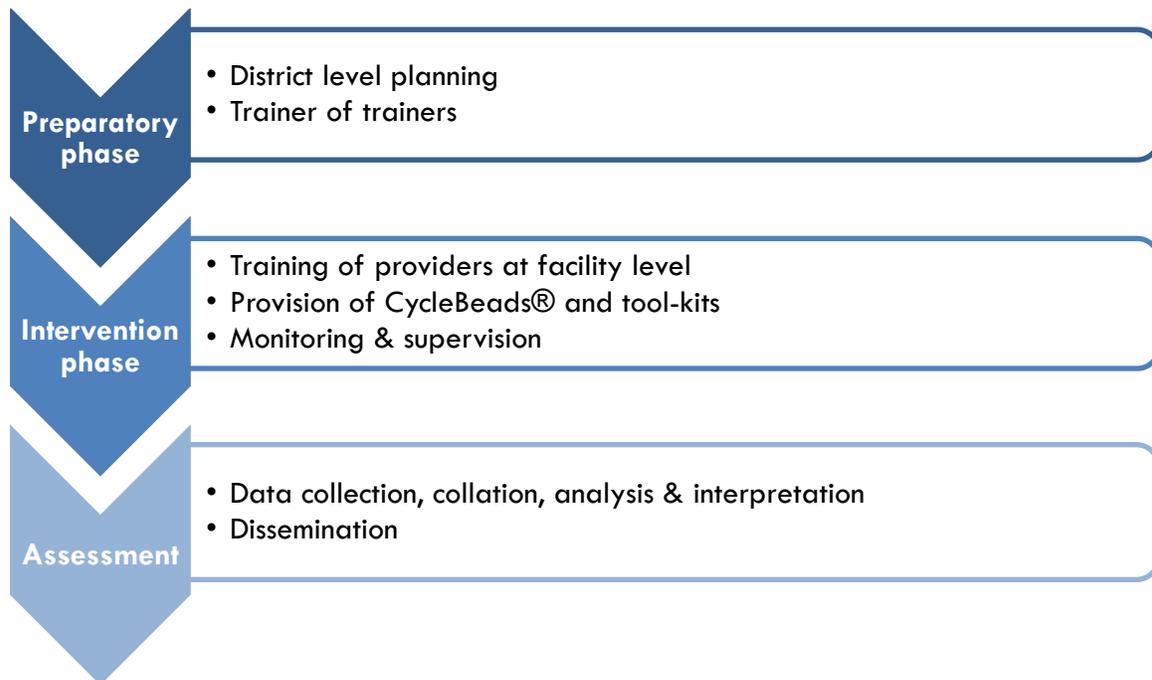
2.2. Study Area

This study was carried out in 85 health facilities across six (6) political districts in three (3) regions. The districts were: LEKMA and Ayawaso sub-metropolitan area (Greater Accra), Ajumako-Eyan-Essiam and Twifo-Heman-Lower Denkyira (Central Region), Amenfi West and Juabeso (Western Region).

2.3. Study Population

The study population was made of health providers and especially those involved in family planning services and reproductive health, and women in their reproductive age accessing family planning services at these health facilities.

2.4. Preparatory, Intervention, and Assessment Steps



2.5. Study Procedures

The Department of Community Health, Kwame Nkrumah University of Science & Technology-School of Medical Sciences (KNUST-SMS) coordinated the research and, supervised the field survey, the data collection, the data management, analysis and report writing.

2.5.1. Recruitment and training of research staff

The following categories of field staff were recruited to undergo training to undertake the study: field data collectors (14), data entry clerks (6), supervisors (5) and one data manager/statistician. The evaluation involved a-16 member team. Over the period November 3 – 9, 2012, KNUST undertook community entry activities at the regional and district levels in the study areas. The community entry activities involved introduction of the study to the regional and district health administrations of the study area. A5-day training was held at the Kwame Nkrumah University of Science and Technology-School of Medical Sciences in Kumasi for the study team. The training focused on the followed areas:

- The overview of the project, theory on menstrual cycle and its implication in family planning methods.
- Principle of natural family planning methods including SDM
- Practice on how to use CycleBeads®
- Description of some of the key family planning methods

- Consent seeking process from both the providers and clients before administering the questionnaires and assessing competencies
- Translation of questionnaire into Twi, Fanti and Ga, and back-translation into English. The art of questioning and data extraction techniques
- Pretesting

To ensure good field practice, the trained field staff were assessed and the best were retained for the actual fieldwork; ten data collectors, three data entry clerks, and three supervisors.

2.5.2. Data collection

SDM assessment data collection commenced on November 18, 2012, simultaneously at all the study sites in all the study districts. Two research assistants (a female and a male) were allotted to each district with one supervisor who was responsible for the two districts in the same region. The female research assistant collected data from SDM users, while the male counterpart collected data from the service records; both interviewed and assessed the family planning provider. The various District Health administrations made available annotated maps of the districts to assist the research team to locate the various health facilities. On the average, two health facilities were visited each day and the period of field data collection was from November 18 to December 21, 2012. The data on new FP users, SDM users, SDM/IEC activities were collected and a physical audit of FP commodities records was undertaken. Additionally, FP registers were reviewed and the requisite information extracted. One guided interview was carried out with one FP service provider who had been trained to offer and has been offering SDM. Individual interviews were held with randomly sampled SDM users from the facility's FP register; to be eligible, the SDM user must have been using the SDM for at least 3 months.

2.5.3. Data analysis and reporting

The GHS-District Health administrations and health facilities had the responsibility for ensuring good monitoring, data capture on new users, and awareness creation activities in participating districts. KNUST undertook more detailed analysis of available service data periodically. Data from the survey of health facility records were cleaned by running programs on legal values and consistency checks. Descriptive statistics were summarized and displayed in tables and graphs. Data entry and preliminary analysis were done in MS Access and more detailed analysis done with STATA 12.0 for windows.

The assessment would also derive from a stakeholder review of the findings, conclusions and recommendations directed at definition of processes and mechanisms for integrating SDM into the Ghana FP program.

2.5.4. Study limitations and field challenges

While every effort was made to ensure the validity and reliability of the study tools, cultural and language factors may have affected the ways in which questions were asked by interviewers, and understood by respondents. Reporting on human behavior is extremely challenging. Many study participants may know the appropriate practice and hence report that behavior (social desirability) but may not necessarily practice it.

Providers: Generally, during the facility visits by the team, the prominent setback encountered in all the health facilities was very poor record keeping. All the health facilities in the districts did not have one kind or another of essential data. For example, the marital status, level of schooling, occupation, number of pregnancies, previous method of contraception, management of fertile period were rarely captured in any of the facilities visited. Apparently, some of these details were recorded in the family planning cards which were mostly kept by the FP clients. For that reason some of the information was provided verbally by the service providers. In many instances, records from the family planning register (service statistics) did not tally with the records from the SDM register.

There were no eligible providers to be interviewed in some of the health facilities. Some SDM-trained providers had been transferred to other facilities while others had gone on maternity or study leave. Other family planning providers stated they were not trained on SDM hence did not have the requisite skills to provide the SDM service. One FP provider in a CHPS zone reported she was never provided with the SDM commodity. No supervision had been carried out in this facility for the study period. This situation was confirmed by the acting District Public Health Nurse (DPHN). According to her, the lack of supervision was due to insufficient funds allocated for monitoring and supervision activities. It was also observed that most of the facilities, did not keep records on the male and female condoms although they had them in stock and many had been given out to clients.

Clients: Both clients and providers cooperated with the study team, and opted to be part of the study by signing or thumb printing on the consent forms; a 100% response rate was achieved. The teams however, faced the challenge of getting contact numbers of SDM clients in health facilities. In instances when eligible clients were not available in person in the district, phone interviews were conducted. It was observed that almost all facilities visited did not keep demographic information such as marital status, and level of education of their clients. Additionally, there were no records of their contact numbers or residential addresses for tracking and monitoring to be done when necessary. The only time when clients could be monitored was when they came to the facility voluntarily with a problem or to reinforce a method. Some clients reported that SDM had assisted them to recognize their fertile periods to enhance sexual activity for conception. Generally, the team realized that compared with modern methods such as injectables, implants and the male condom, SDM uptake was low in the various health facilities. Some women reported that their partners were uncomfortable with the “long” unsafe period days on the CycleBeads® and so these women did not have the support of their partners to use SDM.

2.6. Ethical issues

Administrative clearance for the study was obtained from the various health administrations and facility in-charges while written consent was obtained from the respondents. The Committee for Human Research, Publications and Ethics (CHRPE) of KNUST-SMS provided ethical clearance for the study.

Results and Discussion

3.1. Introduction

This chapter presents the findings and the discussion of these findings from the study. These findings include data collated and analyzed from FP user statistics, FP registers, physical audit of FP commodities, SDM/IEC activities, providers' interviews and SDM users' interviews. The results are quantitative in the most cases with some qualitative.

3.2. Background characteristics of SDM users

Majority (65%) of SDM users were within the age group of 20-29 years, followed by those within 30-39 years (21%); 11% were within their teens. Over 60% of the SDM users were married while more than half (54%) of the users had primary school education. Farming was the most common occupation; more than 40% of the users were engaged in farming. Only a little over 5% were former users of other contraceptive methods while the average numbers of pregnancy and children per user were 2 and 2 respectively. [Table 1]

Table 1: Socio-demographic characteristics of SDM users

Socio-demographic characteristics		
Age group (n=888)	Frequency	%
12-19	95	10.7
20-24	282	31.8
25-29	298	33.6
30-34	133	15.0
35-39	54	6.1
40-44	16	1.8
45-49	7	0.8
≥50	3	0.3
Marital status (n=216)	Frequency	%
Married	138	64.0
Single	78	36.1
Education level (n=147)	Frequency	%
No formal education	4	2.7
Primary school education	79	53.8
Secondary school education	30	20.4
Tertiary education	34	23.1
Client occupation (n=151)	Frequency	%
Unemployed	1	0.7
Agriculture	63	41.7
Student	15	9.9
Civil servant	42	27.8
Business/ trading	30	19.9
Age	Range	Mean
Age range (n= 888)	17 – 65	26.1

RH history	Frequency	%
Ever use of FP (n=916)	53	5.8
	Range	Mean
Number of pregnancies (n= 285)	1- 10	1.84
Number of living children (n= 349)	1-10	1.75

SDM was mostly used by married women who were aged 20 - 29 years. Even though the range of the number of children alive was 1 – 10, on the average each woman had 2 children which is lower than the national fertility rate of 4.0.

3.3. Competence level of SDM users

Competence in the use of SDM was assessed among clients who had used the method for more than three (3) months. Generally, the competence level of SDM users was quite high which implies that SDM could be introduced to the clients as an alternative to other family planning methods; an average score of 78% was recorded. However, only 52% of the users scored all points correctly in demonstrating the use of CycleBeads®. [Table 2]

Table 2: Competence level of SDM users

SDM user's ability to use CycleBeads correctly	Frequency	%
Move ring to red bead first day of cycle (n=86)	81	94.2
Move ring one bead each day (n=86)	84	97.7
Move ring in the direction of arrow (n=86)	48	55.8
Avoid unprotected sex on white bead days (n=86)	78	90.7
Unprotected sex OK on brown bead days (n= 85)	46	53.5
Mark first day of period on calendar (n= 85)	64	75.3

A few SDM users had difficulty in moving the ring in the direction of the arrow; a skill that is key to the correct use of SDM. Some users also had challenges in recognizing the brown bead days as safe days for unprotected sex.

3.4. Client experience with SDM

Most clients (56%) first heard about the SDM through a health clinic talk/consultation or from a community health worker (52%), while radio (1%) was the least common source. Clients had chosen SDM because they (62%) desired a natural/non-chemical method and almost all (98%) of them were satisfied with their choice of SDM. Majority (97%) of them agreed that it was easy to use, effective in preventing pregnancy when correctly used (100%), and does not cause any side effects and health problems (94%); price was not an issue for any of the clients. A little over 93% of the clients interviewed were still using SDM while a few had stopped because they desired to become pregnant or did not like the method. [Table 3a]

Table 3a: Client experience with SDM use

SDM Client Interview	Frequency	%
Client first learns about SDM/CycleBeads™ (n=86)		
Health clinic talk / consultation	48	55.8
Poster in health clinic	3	3.5
Community health worker	45	52.3
Friend	8	9.3
Family member	3	3.5
Radio	1	1.2
Why client chooses SDM (n=84)		
Effective in preventing pregnancy	25	30.1
Desired natural/non-chemical method	52	61.9
Did not like other methods of FP	14	16.7
Did not like side effects of other methods	26	31.0
Religious reasons	1	1.2
Price	0	0.0
Other reasons(know fertile period and get pregnant)	3	100.0
Satisfied with your choice of SDM (n=86)	84	97.7
Clients agreed with the following statements (n=86)		
SDM is easy to understand	85	98.8
SDM is not hard for your partner to understand	78	90.7
SDM is easy to use	83	96.5
SDM is effective in preventing pregnancy when used correctly	86	100.0
SDM is affordable	85	98.8
SDM is not hard to obtain	70	81.4
Use of SDM is not against your religious beliefs	83	96.5
SDM is acceptable to men	70	81.4
SDM does not have side effects	81	94.2
SDM does not cause health problems	81	94.2
SDM does not interfere with sexual relationships	61	70.9
Clients still using the SDM (n=86)		
Still using the SDM	80	93.0
Why did you decide to stop using SDM (n=5)		
Desire to become pregnant	3	60.0
Did not like the method	3	60.0
Difficulty using SDM	1	20.0
Had irregular periods	2	40.0

**Multiple responses allowed*

Clients were asked to express their opinions about the SDM use. Generally most of the clients said the method was good and comfortable to use. This helped them to know their menstrual cycle better and as natural family planning, they did not fear side effects or have any health concerns. Some however commented that they easily forgot to move the ring on some days of the cycle.

3.5. Male involvement

Male involvement is a big issue in family planning and many programs have struggled to improve male involvement in family planning uptake. The existing family planning methods are heavily directed towards women, it is possible that when current efforts to develop male-centered methods materialize, there might be an improvement in male involvement in family planning. This study assessed male involvement, and partner (male) participation in using SDM was generally low except when they reminded the user to move the ring (64%). Clients' partners managed the fertile days mostly through the use of condom (40%) or a combination of condom and abstinence (25%). Virtually none of them would wash their vagina after sex as a means of managing fertile days. [Table 3b]

Table 3b: Male involvement in SDM use

SDM Client Interview	Frequency	%
Partner participation in using SDM (n=75)		
Moves ring on CycleBeads®	18	24.0
Marks calendar the day my period begins	10	13.3
Reminds me to move the ring	48	64.0
Asks me if we can have unprotected sex	10	13.3
Not have sex /abstains on white bead/fertile days	11	14.7
Uses condoms on fertile days	35	46.7
How client and her partner manage fertile days (n=83)		
Abstinence	20	24.1
Condom	33	39.8
Abstinence & condom	21	25.3
Withdrawal	3	3.6
Use no method	4	4.8
Wanted to be pregnant	1	1.2
Wash vagina after sex	1	1.2

**Multiple responses allowed*

3.6. Competence level of providers at offering SDM as a FP method

Provider competence at offering a family planning method is essential to improving uptake of the method; providers have been blamed for 'pushing' methods with which they are 'comfortable.' Generally, the competence level of the providers was very high, an indication that they could rightly offer the SDM to clients. An average score of 91% was recorded as the competence level of the

providers offering SDM as a family planning method to clients across the health centers in the six districts of the three regions. During the survey, 75% of the providers were able to correctly demonstrate how the CycleBeads® are used, and correctly answered all questions related to SDM use. [Table 4]

However, a few of them failed to adequately demonstrate knowledge and skill in the following areas:

- Who can use the SDM?
- When can a woman start using the SDM?
- When can a post-partum woman who is breastfeeding her baby, start using CycleBeads®?
- When can a woman who was recently using contraceptive pills, start using CycleBeads®?

Table 4: Competence level of providers at offering SDM

SDM providers ability to use CycleBeads® correctly (n=80)	Frequency	%
CycleBeads® represent the menstrual cycle	78	97.5
Moves the black ring in the direction of arrow	79	98.8
Early bleeding (bleeding starts before dark brown bead)	79	98.8
Late bleeding (continuous bleeding after last brown bead)	78	97.5
Marks the first day of bleeding on the calendar	79	98.8
Uses calendar date to update missed ring movement	77	96.3
Uses red bead date to update missed beads	76	95.0
Women who qualify to use SDM	73	91.3
Couples who qualify to use SDM	73	91.3
When a woman can start using the CBs	75	93.8
What to do when woman forgets her LMP	71	88.8
When post-partum woman can start using the CBs	69	86.3
Post-partum woman has a month interval between bleeding	68	85.0
What woman on contraceptive pills should do	69	86.3
Woman on contraceptive pills can start using the CBs	61	76.3
When user should contact the health provider	65	81.3

It was unclear whether the providers who had challenges in addressing some of the questions had been trained by SDM trainers or were the ‘second generation’ of trained providers; staff who only received training on-the-job by trained colleague providers.

3.7. Introduction of SDM and effect on uptake of other contraceptive methods

When new family planning methods are introduced into existing family planning services, programmers express concern about women switching from other methods to the new method; if the switch is from more effective methods to less effective ones the concern is even greater. Contraceptive use is greater where a larger number of methods are made available to a large proportion of the population. During the study, an assessment of the effect of the introduction of the SDM into the FP activities in Ghana was carried out in all the health facilities in the six study

districts. A number of variables were assessed using data from the SDM registers at the study facilities.

The proportion of users switching from other methods to SDM was 6%. The user discontinuation rate of SDM was 2% (16) with reasons for the discontinuation including: difficulties in managing the fertile period, desire to have a child, and partner disapproval of the method. Reason for couples choosing the SDM method included: the need for contraception (24%) and personal conviction (30%) while side effects and dislike of other contraceptive methods were 27% and 15% respectively. The management of the fertile period by the couples during the use of SDM was mostly by the use of condoms (54%) and closely followed by abstinence (42%). Withdrawal was used by 2% and 1% used a spermicidal. [Table 5a]

Table 5a: SDM effect on other contraceptive methods (SDM Register)

Variable	Frequency	%
Ever used contraception (n=916)	53	5.8
Users of SDM (n=916)	863	94.2
Reasons for choosing SDM (n=168)		
Desire contraception	41	24.4
Personal conviction	51	30.4
Dislike other FP methods	26	27.4
Side effects of other methods	46	15.5
Other reasons	4	2.4
All SDM acceptors (n=916)		
Number of SDM continuous users	900	98.3
Number leaving SDM	16	1.8
Reasons for leaving SDM (n=7)		
Desiring to have a child	3	42.9
Husband did not want to continue with method	1	14.3
Difficulties in managing fertile period	3	42.9
Management of fertile days (n= 139)		
Practiced abstinence	59	42.5
Use condoms	75	54.0
Use spermicidal	2	1.4
Practiced withdrawal	3	2.2

Information from the SDM registers regarding reasons for choosing SDM, reasons for discontinuing SDM, and management of fertile period were along the same lines as recorded during the client interviews. The details of the client interviews have been presented in Table 3b. Data from the family planning registers (service statistics) did not tally with the data from the SDM registers; the SDM registers had recorded 916 users while the family planning registers had recorded 1151 SDM users. The SDM registers were provided by the project to facilitate the tracking of SDM uptake. Across the study districts, Ajumako-Enyan-Essiam (AEE) in the Central Region recorded the highest number of FP users 9672(46%) while LEKMA in the Greater Accra Region recorded 1055 (5%). According to the data retrieved from the FP registers across the study sites, the total number of new users of SDM was 1151 and hence the SDM contribution to method mix was 5.51%. [Table 5b]

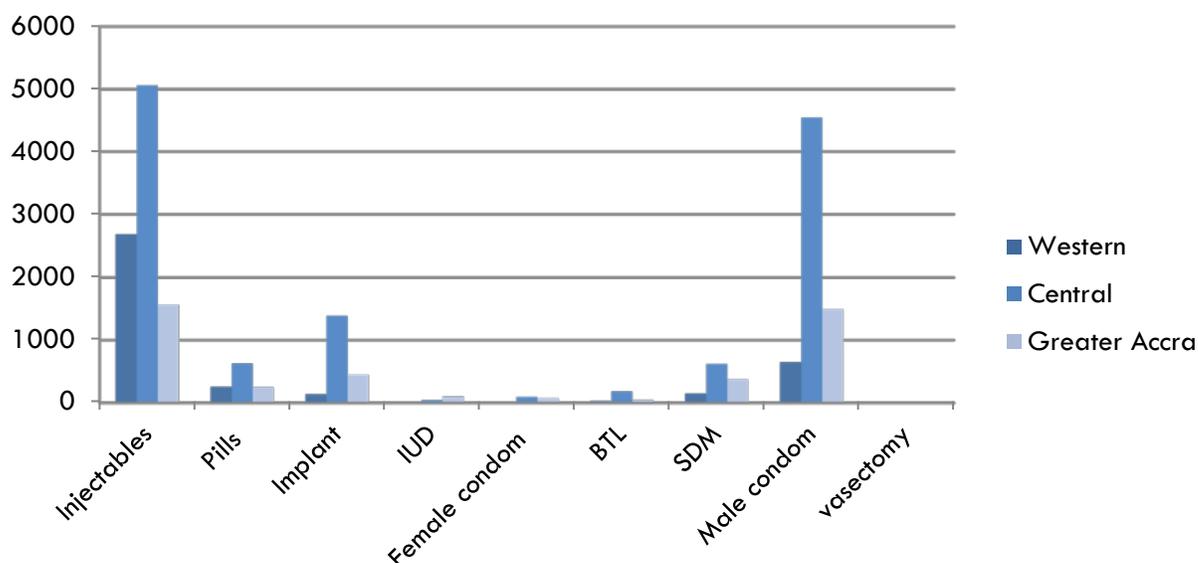
Table 5b: SDM adoption, usage and effect on other contraceptive methods (Service Statistics)

Variable	Frequency	%
District level contraceptive use (n=20887)		
Juaboso	945	4.5
WassaAmenfi West	2995	14.3
Twifo-Heman-Lower Denkyira	2905	13.9
Ajumako-Eyan-Essiam	9672	46.3
Ayawaso	3315	15.9
LEKMA	1055	5.1
SDM contribution to FP method use mix (n=20887)		
SDM users/contribution to method mix	1151	5.5
New users of other FP methods	19736	94.5

3.8. SDM contribution to method mix in the three regions

Improving the method mix for contraceptive users is seen as an opportunity to improve uptake; when clients have access to a wide range of available contraceptives, they are likely to find one most suitable for them. Across the three (3) regions, injectables, male condoms and implants were most commonly used methods; Central Region recorded the highest uptake for each method. Female condoms and vasectomy were rarely used in any region. The level of uptake recorded for implants as a modern contraceptive, is quite encouraging; it is likely that the long term of protection offered by the implant is more convenient for clients since they don't have to return for service as often as with other methods. The privacy offered by implants may be an additional factor influencing the high uptake.

Figure1: The regional distribution of the different contraceptive methods



Vasectomy was provided in the Ajumako-Eyan-Essiam district and LEKMA. The highest new users of contraceptives was also recorded in Ajumako-Eyan-Essiam (46%) followed by Ayawaso (16%) while Juaboso recorded the lowest (4%) (data not shown).

During the period of data collection, it was reported that Marie Stopes International (MSI) had recently offered free family planning services in the districts in the Central Region, resulting in the sharp increases in the number of reported new users, especially for implants and intra uterine device (IUD). The sharp increases were more pronounced in the Ajumako-Eyan-Essiam district where a program dubbed “Integrated Services” had been introduced, and in which free family planning services were offered; SDM was not part of the methods offered by this activity.

Generally, contraceptive uptake in the Western Region was the lowest and this was more pronounced in the Juaboso district. This could be attributed to its rural nature and constraints in both infrastructure and human resources with some health facilities failing to offer any family planning services. LEKMA in Greater Accra is equally a ‘rural district’ with few health facilities and some of these are private facilities that might not have family planning as a key service and this probably accounts for the low contraceptive uptake.

3.9. Physical audit of FP commodities stock availability and absence of service

The availability of family planning commodities at service points is important for family planning uptake; clients who fail to find the method they currently use may not accept another method or may discontinue use altogether and would be at risk of unintended pregnancy and its attendant problems if they remain sexually active. A total of 84 health facilities were audited for stock availability of CycleBeads® and other FP commodities. For SDM, the percent stock out between February and October was 6% to 17% while 2% of the facilities did not offer this service. For injectables, the highest percent of monthly stock out was recorded in October while the least was recorded in May and June; 1% of the health facilities did not provide this commodity. March and April recorded the highest stock out for the pill while 2% of the facilities did not offer this commodity. Between 34% -52% (nearly half) of facilities had stock outs of implant, IUD and female condom across the study months while 16%, 25% and 22% did not provide the implant, IUD and the female condom respectively. Vasectomy was not available in over a third (35%) of the facilities. [Table 6]

Table 6: Percent of health facilities with monthly stock out of FP commodities

Month	Feb	March	April	May	June	July	Aug	Sept	Oct	No service
Injectables	8.3	8.3	8.3	3.6	3.6	6.0	3.6	6.0	10.7	1.2
Pill	21.4	25.0	25.0	19.1	19.1	21.4	20.2	20.2	21.4	2.4
Implant	49.4	50.6	50.6	47.0	42.2	39.8	39.8	34.9	33.7	15.7
IUD	51.8	51.8	50.6	49.4	50.6	49.4	50.6	49.4	49.4	25.3
Female Condom	49.4	49.4	49.4	48.2	48.2	48.2	48.2	48.2	49.4	21.7
SDM/CycleBeads®	16.9	15.7	15.7	9.6	8.4	6.0	7.2	8.4	7.2	2.4
Male condom	21.7	22.9	21.7	18.1	18.1	18.1	15.7	18.1	20.5	2.4
Vasectomy	57.8	57.8	57.8	56.6	56.6	56.6	56.6	56.6	56.6	34.9

Even though the GHS family planning protocols suggests the availability of all methods at all service points, methods such as the implant, IUD, female condom and vasectomy are not widely available. Challenges with provider skill and competence in the provision of some of these methods may explain the gap but the explanation for the female condom is unclear.

3.10. SDM sensitization and awareness raising activities

Sensitization/awareness-raising on SDM as a new FP method option varied from facility to facility. However, the percentage of monthly outreach/community sensitization activities in all the study facilities ranged from 29% to 76%, while individual counseling activities and, Information, Education and Communication (IE&C) activities ranged from 69% to 92% and 64% to 87% respectively. Meanwhile, 1% of these facilities did not undertake any individual counseling activities while 2% of them did not conduct both outreach/community sensitization activities and IE&C activities. [Table 7]

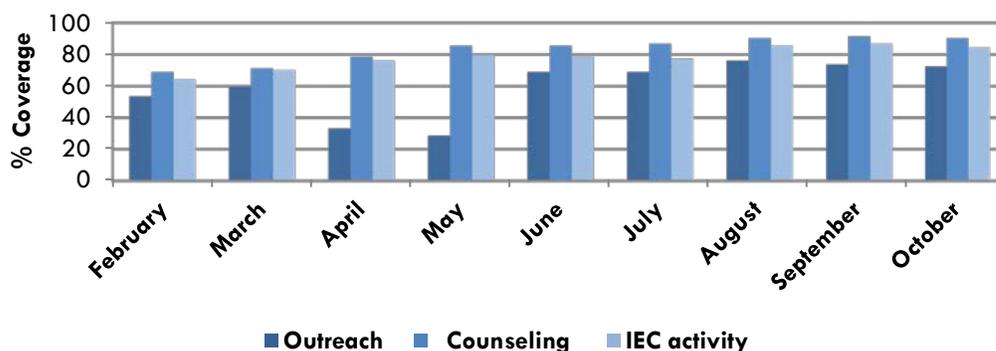
Table 7: Percent of health facilities with monthly BCC Activities that included SDM?

BBC Activity	Feb	March	April	May	June	July	Aug	Sept	Oct	No activity
Outreach	53.6	59.5	33.3	28.6	69.1	69.1	76.2	73.8	72.6	2.4
Counseling	69.1	71.4	78.6	85.7	85.7	86.9	90.5	91.6	90.5	1.2
IEC activity	64.3	70.2	76.2	79.8	78.6	77.4	85.7	86.9	84.5	2.4

Quite a number of health facilities failed to undertake any outreach or IEC activity; and this may possibly be due to inadequate staff and lack of funds (the often cited rhetorical reasons).

On a monthly basis, the proportion of facilities undertaking behavior change and communication (BCC) activities increased from February, peaked in July and remained stagnant till October. Outreach coverage was not particularly impressive at the beginning of the period. Projects do take time to pick up when they start as health providers become better at the service provision as they learn on the job and with time become more competent at its provision.

Figure 2: Percent of health facilities with monthly BBC Activities



Daily individual counseling of women by the Community Health Nurse (CHN) was the most frequently adopted method by most facilities to inform potential users of SDM about a new FP method option. Community sensitization (38%) and weekly home visits (46%) were the least choice methods for reaching potential users where both women and men were often the audience. [Table 8]

Table 8: Percent of health facility activities and audience category

Activity	Conductor	%	Audience	%	Freq.	%	³ SDM	%
Waiting room Information	² CHN	75.0	¹ Both	48.0	Daily	53.8	Always	80.0
Individual Counseling	CHN	82.5	Women	50.0	Daily	77.5	Always	83.8
Couple counseling	CHN	76.3	¹ Both	70.0	Daily	50.0	Always	70.0
Home visits	CHN	76.3	¹ Both	57.5	Weekly	46.3	Always	59.5
Community sensitization	CHN	68.8	¹ Both	60.0	Monthly	37.5	Always	51.3

Key: ¹Both = women & men: ²CHN = Community Health Nurse: ³SDM = SDM activities included
 Community sensitization and weekly home visits require additional resources when compared with static services but the practice of service integration can help address this challenge; CHNs should make the best of every opportunity they have with clients by providing a full range of services.

When the providers were asked to recommend which ways would be most efficient for increasing the awareness and knowledge of SDM as an option for contraception in the communities and clinics where they practiced their services, there were a range of answers given. The most cited themes included:

- Education and training of more health staff through workshops on the use of SDM. This will empower providers to be more effective when giving talks at service points, communities, homes, churches, durbars and others.
- Mass education and intensive community sensitization
- During individual counseling sessions
- Provision of teaching and learning materials for counseling sessions, and making available free CycleBeads® to potential users
- Starting early with students in tertiary institutions

3.11. Provider training in SDM counseling

The community health nurse was the most commonly trained health personnel in SDM counseling. These providers took the lead role in providing counseling in the waiting rooms, during home visits and during community durbars. [Table 9] SDM counseling training programs should target CHNs as they appear to be the provider most active in SDM counseling and provision. The sheer numbers and primary roles of CHNs may be responsible for this showing.

Table 9: Summary of people trained in SDM counseling, sexuality and gender themes (February – October, 2012)

Variable	Frequency	%
Cadre of provider offering SDM (n=80)		
Community Health Nurse	66	82.5
Community Health Officer	2	2.5
“Family Planning Provider”	2	2.5
Health Extension Worker/ Nurse aide	1	1.3
Matron	3	3.8
Midwife	6	7.5
Educational information in waiting room (n=80)		
Do not give	9	11.3
Community Health Nurse	60	75.0
Community Health Officer	2	2.5
“Family Planning Provider”	1	1.3
Health Extension Worker/Nurse aide	2	2.5
Physician Assistant	1	1.3
Midwife	5	6.3
Cadre of provider involved in counseling (n=80)		
Community Health Nurse	66	82.5
Community Health Officer	3	3.8
Health Extension Worker/Nurse aide	2	2.5
Matron	3	3.8
Midwife	6	7.5
Cadre of provider involved in home visits (n=80)		
Community Health Nurse	75	93.8
Community Health Officer	3	3.8
Health Extension Worker/Nurse aide	2	2.5
Provider involved in community visits (n=80)		
Community Health Nurse	74	92.5
Community Health Officer	3	3.8
Health Extension Worker/Nurse aide	1	1.3
Midwife	2	2.5

“Family Planning Provider” – Health worker who has received further training to provide FP

3.12. Qualitative Data

Perception on SDM use by both clients and providers: Most of the providers opined that, the introduction of SDM as an option for family planning appears to address the issue of side effects, and there was zero return of SDM clients to them with issues related to side effects. Clients using the methods never reported problems of side effects unlike users of other methods. Providers also reported that some clients were satisfied with the method and it was convenient for them to administer and affordable. Providers however had difficulty teaching the clients, especially those with a limited education level. Providers also reported that clients with low education were not really interested in the method since some clients were using a contraceptive without the knowledge of their partners, and the use of SDM would expose them to their partners. Some providers thought SDM was good for infertility cases; some SDM users had been able to correctly identify their fertile days and got pregnant.

Tracking current and new SDM users: Some providers explained they used various means to reach their clients including phone calls, home visits, and scheduled appointments, self-reporting by clients while other providers had no tracking system to verify whether their clients were correctly applying the method. The provider considers the client as SDM user when she both accepts and receives the CycleBeads® and has been taught how to use it. These clients were then subsequently registered as such.

Benefits: The benefits of providing family planning services according to most providers includes: the reduction of unplanned pregnancy, allow birth spacing, and economic benefits among others. Providers added that FP also helps to reduce abortion cases, maternal deaths and newborn deaths. Some providers said SDM reduces their work load at the facility and improves their counseling skills and effectiveness.

Supervisor support: Most providers had supervisors who supplied them with family planning commodities and assisted them during counseling sessions. Supervisors reportedly organized trainings and introduced every new commodity to providers. Some supervisors supplied providers with posters and flip charts and observed the general work environment during visits. However, there were some facilities without any supervisors, and some had never received any supervisory visit.

CycleBeads® supply chain: Most facility supplies were through requisitions sent to the district and/or regional levels. The requests to the districts were usually directed to the public health nurse at the district level. A few facilities had supplies through the sub-district level.

Maintaining your supply of contraceptives : A few facilities have problems maintaining their stock of FP commodities in general while most of the facilities reported they did not have any problem with their supplies. Only a few of the facilities have no storage space to store their supplies.

How men and women hear about family planning methods: Providers reported that the most often used means to reach the clients (men & women) was through outreach services to communities and home visits. Antenatal sessions and child welfare clinics offered additional opportunities to talk about family planning. Only a very few however, said through a radio health education program.

Most efficient ways to increase knowledge of SDM at clinics and communities: Many providers said during health talks in the waiting rooms/Out Patient Department, the CycleBead® should be exhibited and demonstrated to all the clients. Many providers thought the most efficient means would be to educate all patients at the Out Patient Department, and at the community level, mount huge posters. Others however said improving, increasing and intensifying community sensitization and individual counseling was the way to go. A few of them thought community sensitization should target the youth and students, and that TV and radio should be used for awareness-creation.

SDM has its own column in the family planning reporting register: Most providers said they did not have to create a column solely for SDM in their family planning register for reporting the number of SDM users as a family planning option as the space already existed.

Support for accurately reporting SDM use: According to most providers, reporting the number of SDM users could be enhanced through the use of a separate register. Many would like the district to create new FP books while the minority would prefer a computer for recording and storage of all family planning information including SDM.

Ideas for reduction of potential obstacles to including SDM into family planning services: The following were ideas given by providers as means of reducing potential obstacles to introducing SDM into the family planning services in Ghana:

- SDM should be covered by the National Health Insurance Scheme and be made free and accessible as other FP methods, if it is expanded nationwide
- Intensification on SDM education in churches and other organized groups and community sensitization
- Training more staff to offer the method
- Train community-based volunteers on SDM to reach more people

Advice to GHS for possible expansion of SDM services to other districts:

- GHS should train FP providers and train more other health workers
- Workshops should be organized for health providers
- GHS should make the CycleBeads® readily available
- Intensive sensitization in the communities
- Intensify education of communities involving both males and females

Conclusions and Recommendations

4.1. Conclusions

Based on the results, the following conclusions were drawn:

The SDM offers a veritable option for increasing the method mix in Ghana. The SDM made a 6% contribution to the method mix in the study facilities; 1151 of the 20887 new users of family planning chose the CycleBeads®

The introduction of SDM did not lead to many users switching from other methods to SDM; only 6% of users switched to SDM. The user discontinuation rate for SDM was very low (2%).

Family planning providers demonstrated a very high level of competence in offering SDM however this was not universal; 75% of providers correctly demonstrated how to use CycleBeads® and correctly answered all questions related to SDM use.

SDM users performed averagely in demonstrating competence in SDM use; 52% of users scored maximum points in demonstrating SDM use. Half of SDM users had difficulty in moving the ring in the direction of the arrow, and in recognizing their safe days. There was universal (98%) satisfaction with the SDM among the users.

Except for actions involving the movement of the ring, male involvement was quite low; 24% moved the ring for the CycleBeads® and 64% reminded the women to move the ring. While some men were uncooperative in the management of fertile days, most couples managed fertile days through condom use. Women who use family planning without the knowledge of their partners cannot use the CycleBeads®.

4.2. Recommendations

Given provider and user satisfaction with SDM, and the contribution that SDM is making to services in the pilot districts (providing 6% of new FP users), the Ghana Health Service may favorably consider adding CycleBeads® to FP services.

As discussed in the May 3, 2013 meeting to share the evaluation findings with FP stakeholders, this introductory process should address the timing and pace of introduction across the country and expansion should be done in a planned fashion to ensure quality of service integration and provision of SDM. It will be important to consider ways to ensure the supply of CycleBeads.

Based on the findings in this evaluation, some areas of weakness were found in service provision. In future training of providers to offer the method, attention should be paid to provider competence in these areas:

- Who can use the SDM?
- When can a woman start using SDM?
- When can a postpartum woman who is breastfeeding her infant, start using SDM?
- When can a woman who was recently using the pill, start using SDM?
- Ensuring that providers insist on teaching users about the right direction in which the ring should be moved, and the recognition of safe days.

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Appendices

Appendix A: Study Tools

SDM Client Interview Guide

Health center:
Client number:
Interviewer:
Date of interview:

I would now like to ask you some questions on your experience using the [local term for SDM/CycleBeads®].

1. How did you first learn about the SDM/CycleBeads®? (**Multiple responses possible**)

Health clinic talk / consultation - 1

Poster in health clinic - 2

Community health worker - 3

Friend - 4

Family member - 5

Radio - 6

Other (specify) - 7

Cannot remember / don't know – 9

2. Why did you choose SDM? (**Multiple responses possible**)

Effective in preventing pregnancy – 1

Desired natural/non-chemical method - 2

Did not like other methods of FP - 3

Does not like side effects of other methods - 4

Religious reasons - 5

Price - 6

Other (specify) - 7

Don't know – 9

3. Are you happy (satisfied) with your choice of SDM?

Yes - 1

No - 2

4. I would like to ask you your opinion about the SDM. Please tell me what you think about the SDM.

5. Please tell me if you agree, disagree with the following statements, or if you do not know.

a- SDM is hard to understand.

Agree - 1

Disagree - 2

Don't know - 9

b- SDM is hard for your partner to understand.

Agree - 1

Disagree - 2

Don't know - 9

c- SDM is easy to use.

Agree - 1

Disagree - 2

Don't know - 9

d- SDM is an effective method in preventing pregnancy when used correctly.

Agree - 1

Disagree - 2

Don't know - 9

e- SDM is affordable.

Agree - 1

Disagree - 2

Don't know - 9

f- SDM is hard to obtain.

Agree - 1

Disagree - 2

Don't know - 9

g- Use of SDM is against your religious beliefs.

Agree - 1

Disagree - 2

Don't know - 9

h- SDM is acceptable to men.

Agree - 1

Disagree - 2

Don't know - 9

i- SDM does not have side effects.

Agree - 1

Disagree - 2

Don't know - 9

j- SDM does not cause health problems.

Agree - 1

Disagree - 2

Don't know - 9

k- SDM interferes with sexual relationships.

Agree - 1

Disagree - 2

Don't know - 9

Let's talk now about how you are using SDM.

6. Are you still using the method?

Yes - 1 **[SKIP TO QUESTION 8]**

No - 2

7. If no: Why did you decide to stop using SDM? **(Multiple responses possible)**

Desire to become pregnant - 1

Did not like the method - 2

Difficulty using SDM - 3

Husband dislikes/unsatisfied - 4

Had irregular periods - 5

Wanted to try another method - 6

Other (Specify) - 7

8. How do/did you and your husband/partner manage the fertile days?

Abstinence - 1

Condom - 2

Mix of abstinence and condoms - 3

Withdrawal - 4

Do not use any family planning method and do not abstain – 5

Other (specify) – 6

9. Could you explain to me how you use/used CycleBeads®? (**Give woman a set of CycleBeads®. Mark all points below the woman mentions. Then probe by asking ‘What else can you tell me about how to use CycleBeads®?’**)

- Move rings to red bead first day of cycle - A
- Move ring one bead each day - B
- Move ring in the direction of arrow - C
- Avoid unprotected sex on white bead days - D
- Unprotected sex OK on brown bead days - E
- Mark first day of period on calendar - F
- Other (Specify) - G:
- Don't know – Z

10. Is there anything that you do/did NOT like about using this method? (**Multiple responses possible**)

- Likes everything about the method - 1
- White bead/fertile days are too many/too long - 2
- Husband dislikes managing fertile days - 3
- Other (Specify) – 4: _____

11. How does/did your husband/partner participate in using SDM/CBs? (**Multiple responses possible**)

- Moves ring on CycleBeads® - 1
- Marks calendar day my period begins - 2
- Reminds me to move the ring - 3
- Asks me whether we can have unprotected sex - 4
- Not have sex/abstains on white bead/fertile days - 5
- Uses condoms on fertile days - 6
- Buys condoms - 7
- Other (Specify) - 8 _____
- Don't know / husband not involved - 9

12. I would like you to take a few moments to think about changes you have observed since you began using SDM. Of all the changes you have experienced, could you tell me what is the one most significant change in your life since you began using the SDM? Why is it significant? (**Give woman a few moments to think and then prompt her again**)

FACILITY DATA SHEET

Study ID Number: _____	Study Site: _____	Today's Date: _____
(DD/MM/YR) ____/____/20____		

Name of data collector: _____ Supervisor's name & signature: _____

I. FP: NEW USER STATISTICS (February – October 2012)

FP method:	February	March	April	May	June	July	August	September	October
Injectable									
OCP									
Implant									
IUD									
Female condom									
Female sterilization									
SDM									
Male condom									
Vasectomy									
Foam/Jelly									
Emergency contraceptive									

II. FP COMMODITIES

Stocks at time of survey:	February	March	April	May	June	July	August	September	October
Injectable									
OCP									
Implant									
IUD									
Female condom									
SDM									
Male condom									
Foam/jelly									
Emergency contraceptive									

- Stock out in this month

III. SDM BCC ACTIVITY

BCC Activity:	February	March	April	May	June	July	August	September	October

PROVIDER QUESTIONNAIRE AND ASSESSMENT TOOL

Name of facility: _____

Date of interview: _____

Type of facility (circle): _____

Name of interviewer: _____

Ministry of Health (MH) Clinic / Faith-based Clinic

Let's start with questions about the family planning services that are offered in this facility

1. What do you see as the benefits of providing family planning services in this facility? What disadvantages, if any, do you see?

2. What type of tools and materials do you use to help you with client counseling sessions?

	Available?	Type of Tool or Material (circle)	Other (specify)
Pill	Yes/No	Poster / Job Aid / Flipchart	
Condom	Yes/No	Poster / Job Aid / Flipchart	
Injectables	Yes/No	Poster / Job Aid / Flipchart	
IUDs	Yes/No	Poster / Job Aid / Flipchart	
Standard Days Method	Yes/No	Poster / Job Aid / Flipchart	
Other			

3. Does your supervisor support you in providing family planning services? How?

4. Is the Standard Days Method® included in these supervision activities? How?

5. How does this clinic obtain contraceptives, including CycleBeads®? Please describe the process.

6. Do you ever have problems maintaining your supply of contraceptives (stock outs, prohibitive cost, etc.)?

7. If yes, do you have concerns about being able to obtain CycleBeads® when you need them?

Next, let's talk about the role of the Standard Days Method in family planning services

8. What do you think about offering the Standard Days Method in your family planning services? Do you see advantages?

For providers?

For clients?

Do you think there are disadvantages?

For providers?

For clients?

Next, we will talk about how clients learn about the Standard Days Method

9. In general, how do men and women in this district hear about family planning methods (and their availability)?

10. How do you inform potential clients about family planning methods? (**Record all answers in corresponding square. Put NA or "not applicable" in remaining squares**)

Family planning educational activity	Person normally conducting educational activity	Who is the audience? (Women, men, both, couples, others)	Frequency (daily, weekly, monthly, semesterly)	Is Standard Days Method® is included in these educational activities? Never/Sometimes/Always
Information in the waiting room				
Individual counseling				
Couples counseling				
Home visits				
Community sensitization				
Other (specify)				

11. What do you think would be the most efficient ways to increase knowledge of the Standard Days Method in your clinics? In the communities that your organization serves?

Now we can talk about reporting and monitoring of family planning users

12. How do you track current and new Standard Days Method users? Please explain.

13. At what point is a woman considered a Standard Days Method user? (ex: when she receives CycleBeads®? When she returns for a follow-up visit?)

14. Does Standard Days Method have its own column in the family planning reporting register?

15. What would help you more accurately report Standard Days Method use?

Now I will ask about your opinions relating to political considerations of introducing the Standard Days Method

16. In your opinion, how could the political environment in the Ghana Health Service (GHS) and among donor agencies and other multilateral organizations affect including the Standard Days Method?

17. In your opinion, how could the political environment in the Church and the dioceses affect including the Standard Days Method?

18. Do you have any other ideas about how to reduce potential obstacles for including the Standard Days Method into family planning services?

19. If the GHS wants to expand SDM services to other districts, what advice would you have?

20.	Explain how CycleBeads® are used. (Give a set of CycleBeads® to the provider for demonstration)	Mark 1 for each item correctly demonstrated; mark 0 otherwise
a.	CBs represent the menstrual cycle of a woman. Each bead of the CBs represents a day of the menstrual cycle	
b.	The red bead represents the first day of menstrual bleeding	
c.	All brown beads represent days when pregnancy is unlikely to occur	
d.	All white beads represent days when pregnancy is most likely to occur	
e.	On the first day of menstrual bleeding, move the black band on to the RED bead	
f.	Consecutively, mark that day on the calendar	
g.	Move the black band to the next bead every day (even on days of menstrual bleeding)	
h.	Always move the black band forwards the direction of arrow	
i.	Use a condom or abstain during the white bead days	
j.	On Brown Bead days, couple may have sex without using a condom	
k.	On the start of your next menstrual bleeding, skip the left-over brown beads and move the black band on to the red bead. Leave aside the left-over beads, if any	
l.	If the menstrual bleeding start before the black band reaches the dark brown bead, it means her periods (menstrual bleeding) have come early	
m.	If the menstrual bleeding does not start even after the black band reaches the last brown bead, the periods (menstrual bleeding) are late	
21. What should the woman do, if she forgets to move the black band?		
a.	Check the first day of the woman's menstrual cycle on the calendar	
b.	Start counting days from that day to the present date and count the number of days that have passed in her menstrual cycle	
c.	Then, starting from the red bead, count those many number of beads, and move the black band on to the correct bead	
22. Who can use the SDM?		
1.	Women who have their periods (menstrual bleeding) once a month, or in other words whose periods come a month apart	
2.	A couple who is willing to use a condom or abstain on the days when the pregnancy is likely to occur (white bead days)	
23. When can a woman start using the SDM?		
a.	A woman who remembers the date of her LMP, she can start using the CBs from the same day	
b.	If a woman doesn't remember the date of her LMP, she would have to wait for the next menstrual bleeding to start using the CBs. The couple has to use condom or abstain till the time next bleeding starts. The woman will start using CBs from the first day of the next menstrual bleeding	

24.	When can a post-partum woman who is breast-feeding her baby, start using CBs?	
a.	The woman must have had menstrual bleeding for at least four times since birth of the baby	
b.	There must be a difference of one month between the last two menstrual bleeding	
c.	Also advise that the next pregnancy should be planned only after two years.	
25.	When can a woman who was recently using contraceptive pills, start using CBs?	
a.	The woman had a difference of one month between two menstrual bleeding, before she started using oral contraceptive pills	
b.	After stopping oral contraceptive pills, the woman must have had at least 3 menstrual bleeding (periods) with an interval of 1 month between them	

26.	Under which circumstances must a woman using CBs, contact the health provider?	
1.	The woman starts menstruating before the black band reaches the dark brown bead (Early menstrual bleeding)	
2.	The woman's menstrual bleeding does not start even after the black band reaches the last brown bead (Late menstrual bleeding)	
3.	If the couple did not use condoms or abstain on the white bead days	
4.	If the woman thinks she is pregnant	
5.	If the couple is not satisfied with CBs	
27.	How effective is the SDM?	
	SDM is 95% effective. In other words, out of 100 women who are using SDM, there is a probability that 5 women might get pregnant	
28.	Why is it important for CBs users to move the black band every day?	
a.	By moving the black band every day, the woman will be able to identify days when she is fertile and likely to get pregnant	
b.	It helps her to know if her periods have come early (before the black band reaches the dark brown bead)	
c.	It helps her to know if her periods have come late (even after the black band reaches the last brown bead)	

Appendix B: Detailed assessment of SDM providers (n=80)

CBs represent the menstrual cycle of a woman. Each bead of the CBs represents a day of the menstrual cycle	Freq	%
The red bead represents the first day of menstrual bleeding	78	97.50
All brown beads represent days when pregnancy is unlikely to occur	80	100
All white beads represent days when pregnancy is most likely to occur	80	100
On the first day of menstrual bleeding, move the black band on to the RED bead	80	100
Consecutively, mark that day on the calendar	80	100
Move the black band to the next bead every day (even on days of menstrual bleeding)	80	100
Always move the black band forwards the direction of arrow	80	100
Use a condom or abstain during the white bead days	79	98.75
On Brown Bead days, couple may have sex without using a condom	80	100
On the start of your next menstrual bleeding, skip the left-over brown beads and move the black band on to the red bead. Leave aside the left-over beads, if any	80	100
If the menstrual bleeding start before the black band reaches the dark brown bead, it means her periods (menstrual bleeding) have come early	79	98.75
If the menstrual bleeding does not start even after the black band reaches the last brown bead, the periods (menstrual bleeding) are late	78	97.50
What should the woman do, if she forgets to move the black band?		
Check the first day of the woman's menstrual cycle on the calendar	79	98.75
Start counting days from that day to the present date and count the number of days that have passed in her menstrual cycle	77	96.25
Then, starting from the red bead, count those many number of beads, and move the black band on to the correct bead	76	95.00
Who can use the SDM?		
Women who have their periods (menstrual bleeding) once a month, or in other words whose periods come a month apart	73	91.25
A couple who is willing to use a condom or abstain on the days when the pregnancy is likely to occur (white bead days)	73	91.25
When can a woman start using the SDM?		
A woman who remembers the date of her LMP, she can start using the CBs from the same day	75	93.75
If a woman doesn't remember the date of her LMP, she would have to wait for the next menstrual bleeding to start using the CBs. The couple has to use condom or abstain till the time next bleeding starts. The woman will start using CBs from the first day of the next menstrual bleeding	72	90.00

When can a post-partum woman who is breast-feeding her baby, start using CBs?		
The woman must have had menstrual bleeding for at least four times since birth of the baby	69	86.25
There must be a difference of one month between the last two menstrual bleeding	68	85.00
Also advise that the next pregnancy should be planned only after two years.	71	88.75
When can a woman who was recently using contraceptive pills, start using CBs?		
The woman had a difference of one month between two menstrual bleeding, before she started using oral contraceptive pills	69	86.25
After stopping oral contraceptive pills, the woman must have had at least 3 menstrual bleeding (periods) with an interval of 1 month between them	61	76.25

Under which circumstances must a woman using CBs, contact the health provider?		
The woman starts menstruating before the black band reaches the dark brown bead (Early menstrual bleeding)	76	95.00
The woman's menstrual bleeding does not start even after the black band reaches the last brown bead (Late menstrual bleeding)	74	92.50
If the couple did not use condoms or abstain on the white bead days	76	95.00
If the woman thinks she is pregnant	75	93.75
If the couple is not satisfied with CBs	75	93.75
How effective is the SDM?		
SDM is 95% effective. In other words, out of 100 women who are using SDM, there is a probability that 5 women might get pregnant	65	81.25
Why is it important for CBs users to move the black band every day?		
By moving the black band every day, the woman will be able to identify days when she is fertile and likely to get pregnant	78	97.50
It helps her to know if her periods have come early (before the black band reaches the dark brown bead)	77	96.25
It helps her to know if her periods have come late (even after the black band reaches the last brown bead)	74	92.50

Appendix C: Participating health facilities by type and region

Greater Accra Region

District 1: Ledzokuku Krowor (LEKMA)

	Name of Facility
1	LEKMA Hospital
2	Nungua RCH Clinic
3	Family Health Hospital
4	Finger Of God Maternity Home
5	Manna Mission Hospital
6	Robert Martins Clinic
7	Christian Medical Center
8	Akpeshika CHPS Zone

District 2: Ayawaso sub-metropolis

	Name of Facility
1	Maamobi Hospital
2	37 Military hospital
3	Nima Gov't hospital
4	Nyaho Hospital
5	Legon Hospital
6	Malata Clinic
7	Urban Aid (Salvation Army)
8	North Dzorwulu CHPS zone
9	Kotobabi zone (King David hospital)
10	Alajo zone (I. C. Quaye premises)

Central Region

District 1: Ajumako-Enyan-Esiam (AEE)

	Name of Facility
1	Bisease HC
2	Ajumako Hospital
3	Abaasa HC
4	Sonkwaa Community Clinic
5	Enyanmaim Community Clinic
6	Kwanyako Community Clinic
7	Mando Community clinic
8	Kromaim CHPS
9	Ekumasi CHPS
10	Ekukrom CHPS
11	Anyinasu CHPS
12	Ahamakrombua CHPS
13	Nkojo CHPS
14	Obontsir CHPS
15	Ampiah Ajumako CHPS
16	Osedzi CHPS
17	D.H.D. Outreach
18	Salvation Army Clinic
19	Ann's Maternity Clinic

District 2: Twifo Hemang Lower Denkyira (THLD)

	Name of Facility
1	Praso RCH
2	Mokwa H/C
3	Hemang H/C
4	Frami H/C
5	Jukwa H/C
6	Florence Maternity Home
7	Nuamakrom CHPS
8	Kortorkyi CHPS
9	Wamaso CHPS
10	Ayaase CHPS
11	Adade Kofi CHPS
12	Shed CHPS
13	Krobo CHPS
14	Kayireku CHPS
15	TOPP Clinic
16	Agona Pentecost Clinic

Western Region

District 1: Juaboso

	Name of Facility
1	Juaboso Hospital
2	Jato CHPS
3	Mafia CHPS
4	Ahyemandiem CHPS
5	Boinzan CHPS
6	Sayerano CHPS
7	Kantankrubo CHPS
8	Bepoase CHPS
9	Puakrom CHPS
10	Nkyensekokor CHPS
11	Asempaneye CHPS
12	Aboboyaa CHPS
13	Bonsu Adamase Clinic
14	Amoaya Health Centre
15	Bodi CHPS
16	Proso CHPS Bonsu CHPS Ahibenso Health Centre

District 2: Wassa Amenfi West

	Name of Facility
1	Samaratex Hospital
2	Asankragwa Catholic Hospital
3	Wesley Clinic
4	Asankragwa RCH
5	St. Theresa's Clinic
6	Somprey CHPS
7	Moseaso CHPS
8	Wassa Dunkwa CHPS
9	Affobrakrom CHPS
10	Bakakore CHPS
11	Anyinabrim CHPS
12	Nkwantanum CHPS
13	Bonuama CHPS