

AWARENESS Project
Introducing the Standard
Days Method® into
Public Sector Services
in Peru



Submitted by:
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Georgetown University
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The *Institute for Reproductive Health*, affiliated with Georgetown University in Washington, D.C., is a leading technical resource and learning center committed to developing and increasing the availability of effective, easy-to-use, natural methods for family planning.

The purpose of the AWARENESS Project was to improve contraceptive choices by expanding natural family planning options and developing new strategies and approaches to increase the reproductive health awareness of individuals and communities in developing countries.

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The AWARENESS Project

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EXECUTIVE SUMMARY

After seeing the yet-unpublished results of the Standard Days Method[®] (SDM) efficacy trial, Peruvian Ministry of Health (MOH) decision-makers expressed interest in adding the method to their regular family planning (FP) services. A three-year pilot introduction project was carried out, designed to develop and test a service delivery model appropriate for the local context and for replication elsewhere in the country. A study component was superimposed on the pilot project to answer key questions the MOH had regarding the SDM's performance in non-study circumstances: 1) if there would be enough demand for the method, 2) whether the SDM would siphon clients from other methods, 3) if pregnancy rates would be in the range of those seen in the efficacy trial, and 4) whether offering and providing the SDM would represent an excessive burden to FP providers.

The SDM was offered and provided to clients at MOH facilities in the Department of San Martín, initially in two provinces, then expanded to most of the department. A cross sectional survey of SDM clients was conducted 18 months after the method became available. Some 1200 women were contacted and interviewed (of 1254 reported as SDM users at the time the interviews were conducted). On average, they had received counseling in the SDM 10 months before.

Although the project had initially been planned for two years, at the request of the local MOH, it was extended for another 12 months. At the end of the project SDM services were available at over 300 facilities throughout the department, offered by over 700 trained providers (most of whom were trained by the MOH using their own personnel and resources).

RESULTS

Demand

A total of over 4100 women had received counseling in the method at the end of the three years; by the end of the project the San Martín MOH Management Information System (MIS) was reporting some 220 additional new SDM users every month, representing approximately 5% of all new FP users (both figures have continued in the same range for more than two years since the project was completed).

Effect on use of other methods

Most women starting the SDM were not using another modern family planning method in the months prior to SDM initiation. Even after the SDM had become widely available at MOH facilities, orals, injectables and condoms continued to attract new users, with 43, 31 and 22% of all new FP users respectively choosing these methods.

Efficacy

Some 105 SDM users (8.8%) reported a pregnancy since starting the SDM; 40% of pregnancies were reported as planned, and another 34% as the result of unprotected

intercourse on fertile days. Less than 2% of users reported becoming pregnant while using the method as instructed (either using condoms or abstaining on fertile days).

Workload

Most providers interviewed were satisfied with the method, mentioning it was easy to provide and did not require significant follow up, and that clients tended to continue using it (many compared this to the high discontinuation figures for hormonal methods).

Results beyond the pilot introduction

The above results were presented to central level MOH decision makers, who agreed that they were favorable. They authorized and facilitated expansion of SDM services to other departments in the country. Since then, the SDM has become available in three other departments and in three Directorates covering most of Lima department.

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ACRONYMS

DIRESA	Dirección Regional de Salud
FAM	Fertility Awareness-based Method
FP	Family Planning
IEC	Information, Education, and Communication
IRH	Institute for Reproductive Health
ISR	Instituto para la Salud Reproductiva-Perú
JHUCCP	Johns Hopkins University Center for Communications Program
KIT	Knowledge Improvement Tool
MIS	Management Information System
MOH	Ministry of Health
PRISMA	Proyectos de Informática, Salud, Medicina y Agricultura
SDM	Standard Days Method [®]
TOT	Training of Trainers
WRA	Women of Reproductive Age

1. INTRODUCTION

1.1 Issue

Throughout the developing world, over 15% of all women in union using family planning are reported as users of a “natural method”, “traditional method” or “periodic abstinence”¹. In Peru this figure is even higher: 26% of all women using family planning are reported as users of a “traditional method”². However, the majority of these women who are reported as users of a traditional method in reality are not using any method. Although the calendar or rhythm method is consistently ranked as the most commonly used method in Peru, most women have little or no knowledge of when in their menstrual cycle they are likely to become pregnant^{3,4}. Most of them are simply abstaining from sexual intercourse at various and varying times of their cycle, based on incomplete and/or incorrect information obtained from unreliable sources⁵. Women using this type of periodic abstinence have at least a 25% annual probability of pregnancy, in spite of adopting a behavior that they think will protect them from pregnancy⁶.

Almost one million women in Peru rely on the calendar method or other traditional practices to avoid becoming pregnant. Additionally, 28% of women in union (presumably sexually active) are not using any family planning, many facing an 85% yearly probability of pregnancy⁷. This represents an additional several hundred thousand women.

In Peru, the most frequently stated reason for not using a family planning method or for not using a “modern” method is side effects associated with some methods (DHS, Peru 2004)⁸. Given this situation, making a simple fertility awareness method (FAM) such as the Standard Days Method[®] (SDM), available to women and couples could greatly contribute to addressing the unmet need for family planning.

1.2 Immediate Problem

The Peruvian Ministry of Health (MOH) was interested in making the SDM available to its clientele as part of its regular services. Two of the sites of the SDM efficacy trial conducted by Georgetown University’s Institute for Reproductive Health (IRH) from

¹ Population Reference Bureau (PRB). 2004 World Population Data Sheet, 2004.

² PRB, 2004.

³ Macro Internacional Inc. Demographic and Health Survey (DHS), Encuesta Demografica y de Salud Familiar 2000/ ENDES 2000. Lima, Peru 2000/Calverton, MD, 2004.

⁴ Instituto de Salud Reproductiva-Peru (ISR). Incorporacion del Metodo de Dias Fijos a los servicios de Planificacion Familiar: Aprendiendo de la Experiencia en la Region de Salud San Martin. Lima, Peru, 2007.

⁵ Instituto de Salud Reproductiva-Peru (ISR). Metodo del Collar: Experiencia Piloto de la Introduccion de un Nuevo Metodo de Planificacion Familiar Natural. Lima, Peru. 2005.

⁶ Hatcher, R. Ed. Contraceptive Technology, 18th Edition. New York: Ardent Media Inc., 2004.

⁷ Hatcher, R, 2004.

⁸ DHS, 2004.

2000 to 2001 were in Peru: one in Juliaca, in the highlands near Lake Titicaca, where field work was done by personnel from the local MOH, and one encompassing several working class communities in the periphery of Lima. In early 2002, soon after the completion of the efficacy trial, IRH shared the results with central level MOH officials. IRH and the MOH began discussions about the possibility of making the SDM available as part of the MOH regular services. The MOH is by far the largest provider of family planning services in the country: in 2001 approximately 70% of all FP services were provided by MOH personnel⁹. So including the SDM into MOH services would make it available to the majority of women, particularly those who are less likely to use other modern methods (i.e., poorer, less educated women, particularly those living in the rural and semi-rural areas¹⁰).

The MOH was very interested in making SDM available countrywide, and it had the capacity to implement SDM services through its service delivery network; but decision makers required evidence that incorporating SDM would have a net positive impact. Some key gatekeepers had questions about how the SDM would perform in terms of demand, efficacy, and cost effectiveness when it was provided as part of regular MOH services (and not in the context of a clinical trial). They raised several specific concerns:

- Whether there would be enough demand for the SDM to justify the personnel time that the MOH would invest in integrating it into its services.
- Whether these clients requesting the SDM would be new users of family planning or they would be switching from other modern methods to the SDM. During the clinical trial, mechanisms had been in place to prevent method switching (for study and for political reasons), but these would not exist once the method was offered as part of regular services. MOH officials were not questioning the importance of free and informed choice of method, but they still wanted to know the immediate family planning history of SDM clients.
- Whether efficacy of the SDM would be comparable to that obtained during the efficacy trial.
- Whether learning the SDM and teaching it to their clients would represent an excessive burden to providers, particularly midwives, who provide most FP services and who were considered to be overloaded already.

1.3 Objectives

From the programmatic side, the main objective of the project was to develop and test a service delivery model appropriate for the local context and for replication elsewhere in the country; this model would include a training strategy, a monitoring and evaluation strategy, and a promotion strategy.

Another programmatic objective was to build local capacity, and integrate the SDM into service delivery support systems in order for SDM services to be technically self-sustainable in the mid term.

⁹ ISR, 2007.

¹⁰ DHS 2004.

The objectives of the study were to generate evidence that would show MOH decision makers that when the SDM was offered and provided as part of regular MOH services:

- There would be significant demand for the SDM.
- The SDM would not take clients away from other modern methods.
- SDM efficacy would be comparable to that obtained during the clinical trial.
- The SDM would not be an excessive burden to providers and other personnel involved.

The MOH, the United States Agency for International Development (USAID) Mission in Peru, IRH, and Instituto para la Salud Reproductiva-Peru (ISR) a local NGO which would be IRH's principal local counterpart, agreed to start the introduction of the SDM to MOH services in a pilot site and the Department of San Martin was selected, with support funding from USAID to IRH.

San Martin

San Martin is located in the northern part of the country, in the "jungle" region of Peru. Its climate is tropical. People living in the jungle area of the country are culturally different from people living in other areas of the country. They are generally considered to be more open to new ideas, friendlier, and in general more relaxed, particularly compared to people living in the Andean highlands. Anecdotal information suggests that outsiders consider men and women from the jungle areas to be sexually more liberal than people from other areas of the country. Jungle area inhabitants share this perception.

Total population of the Department was approximately 600,000, mostly rural. Local contraceptive prevalence was 72%, with 61% using modern methods (both rates slightly higher than the national averages) and almost 12% reporting use of traditional methods.

Operationally, San Martin is divided into ten health networks, which roughly correspond to provinces within the department. Each network is sub-divided into micro-networks. There were some 340 health facilities, distributed unevenly among the ten networks.¹¹

In discussions with Directors of San Martin MOH Directorate (DIRESA), it was decided to make the SDM initially available in only two provinces, Lamas and San Martin, chosen primarily for logistical reasons. San Martin network is the largest in the department, with 98 facilities and some 30,000 women of reproductive age (WRA) at the time; Lamas is the smallest one, with seven facilities and some 13,500 WRA.

2. HYPOTHESES

The study portion of the intervention had several hypotheses, addressing the main questions posed by Central MOH decision makers:

¹¹ Instituto de Salud Reproductiva-Peru. Introducción del Metodo del Collar a los Servicios de Salud. Lima, Peru 2004.

- Adding the SDM to MOH services in San Martin would lead to a “large number” of users of this method. IRH could not venture predictions about how many women would choose the SDSM; thus the MOH agreed they would be satisfied with at least several hundred new users per year.
- Adding the SDM to MOH services in San Martin would not cause a reduction in users of other methods. Again, since IRH could not guarantee that other methods’ numbers would remain unchanged (particularly since stockouts and other disruptions were not infrequent), the MOH agreed to a vague goal: that other methods’ numbers would not decline beyond regular oscillations (which remained quantitatively not defined).
- The number of pregnancies among SDM users in San Martin would not be much higher than during the efficacy trial. The study design would not allow calculation of accurate pregnancy rates, all reporting would be retrospective, and IRH could not venture accurate predictions; so the MOH agreed to this vague goal.
- Adding the SDM to MOH services in San Martin will not represent a large burden to providers or other MOH personnel. The MOH agreed to judge this based on perceptions of providers and others who would be involved in service delivery and related activities.

3. METHODS

3.1 General Description

The project was designed as pilot introduction of the SDM as part of regular services in the public sector network. The study component was superimposed on this. The design of the intervention, procedures, and data collection were largely determined by the goal of determining whether the method would perform well in actual service delivery circumstances, compared to “study circumstances”; frequent or prolonged interaction with clients was perceived as having the potential to influence method choice or method use, or could give the impression that the SDM itself required significant amounts of providers’ time. This limited the amount of follow up, interviews, or other contact with clients, even for data collection purposes.

The method was to be offered and provided to clients of MOH clinics in the designated areas, and a cross-sectional survey of SDM clients was to be conducted at 18 months after the method became available.

3.2 Participants

There were three types of study participants:

- FP service providers offering the SDM at MOH facilities within the designated areas in San Martin;
- Selected MOH supervisors and middle managers involved in the family planning program;
- Clients seeking family planning services and receiving the SDM at MOH facilities within the designated areas in San Martin. (In contrast with the efficacy trial there

were no exclusion criteria related to age, parity, previous or current contraceptive use.)

3.3 Informed consent

- The study protocol, procedures and instruments were approved by the Institutional Review Board of Georgetown University. Additionally, they were submitted to and approved by the Ethics Committee of Proyectos de Informatica, Salud, Medicina y Agricultura (PRISMA), a local Peruvian NGO familiar with externally-funded research and service projects.
- Informed consent to be interviewed at some time in the future was obtained from service providers when they were trained in the SDM; those who were interviewed confirmed their consent immediately before the interview.
- Informed consent obtained from managers and supervisors was obtained immediately before they were interviewed.
- Informed consent to review their clinical charts and to be interviewed at some time in the future was obtained from clients when they received counseling in the SDM. Those who were actually interviewed confirmed their consent immediately before the interview.

3.4 Procedures

Advocacy

IRH and ISR met with key decision makers and other gatekeepers at the MOH and at the San Martin DIRESA, to seek their involvement in planning the project and the study. Other influential persons in San Martin were informed about the project in the weeks and days preceding startup of activities. All the above persons were periodically updated on project and study progress and relevant preliminary results were shared with them as appropriate.

Training

A training of trainers (TOT) for a group of 11 DIRESA trainers, supervisors, managers and selected providers was conducted in August 2002 in Tarapoto, the largest city in San Martin and where the San Martin DIRESA headquarters are located. Several other DIRESA officials (including heads of key offices such as Health Promotion, Training, and Management Information Systems) attended all or parts of the workshop. Topics covered during two days included general characteristics of the SDM, biological bases, service delivery procedures (including screening, counseling and follow-up), procedures to train providers, registry procedures to record SDM users, and quality assurance procedures and tools (including use of the Knowledge Improvement Tool [KIT] a checklist developed to assess quality of SDM services).

This initial TOT was followed in the subsequent weeks by training workshops for providers. A local coordinator hired by ISR worked with designated trainers to schedule and prepare these workshops for providers. Workshops were led by DIRESA staff, with the support of the ISR local coordinator. In most instances, two DIRESA staff from

adjacent or nearby areas were assigned to work in pairs, both co-facilitating workshops for providers in their respective areas. A total of ten training workshops for providers were completed within three months. A total of 103 providers were trained in the initial round of workshops. Given that throughout the MOH system, midwives provide most FP services, training activities were designed and targeted to midwives. Approximately 90% of providers trained in the SDM in this initial round were midwives.

Promotion

The Information, Education and Communication (IEC) strategy was developed jointly by the San Martin DIRESA's Office of Health Promotion, ISR and IRH, with general guidance from the Johns Hopkins University Center for Communications Program (JHUCCP) office in Lima.

All promotional materials were developed and produced by the MOH Office of Health Promotion. Technical support from IRH and ISR for materials development was limited to providing them key facts that should be included in the materials, and electronic files of illustrations, and reviewing drafts of the materials. Three radio spots in Spanish and in Quechua were produced and recorded in-house by MOH staff at almost no cost.

Some promotion for the method started as soon as services became available. Initial activities included a banner for an exterior wall of MOH clinics, a poster for waiting rooms of facilities, distribution of limited amounts of fliers to women who visited facilities, and broadcasting of radio spots. Banners and posters remained in the clinics throughout the project. Fliers were distributed for a few months until the initial supply ran out. Radio spots were broadcast for two months at the beginning of the project and for another two months several months later.

Service Delivery

SDM services became available in a few MOH clinics almost immediately after the first provider training workshops. The ISR local coordinator worked with these providers to ensure they had the necessary skills to start offering and providing the SDM, and that they had the supplies they needed, including job aids and a small initial supply of CycleBeads[®]. After about three months, the SDM was available at 63 MOH facilities, 56 in the San Martin network and 7 in Lamas. For logistical reasons, only facilities from six micro-networks in San Martin network were included.

The initial plan was that the SDM would be available on a pilot basis and only at the above facilities for the duration of the project, through July 2005. Importantly, this was what the Central MOH and the San Martin DIRESA had agreed to. However, about a year after services became available in Lamas and San Martin networks, Directors and/or family planning managers from other networks in the department began contacting ISR staff to inquire about the SDM and to request TA to include it in their services. ISR transmitted this interest to the Central MOH and San Martin DIRESA, along with preliminary information on demand for the method in Lamas and San Martin networks (although this information had been available from MOH service statistics and ISR had been periodically updating key decision makers). The response from the

Central level was that as part of the ongoing process of de-centralization, DIRESAs had the autonomy to decide these issues. The San Martin DIRESA agreed to expand SDM availability to other networks within the department. In early 2004, DIRESA trainers from Lamas and San Martin, with very limited support and guidance from ISR, started training their peers from neighboring districts. Approximately 180 additional providers from some 110 facilities were trained during the next few months.

By the end of the project, the San Martin DIRESA had taken responsibility for training the rest of its providers. It reported 705 providers trained in the SDM and service availability at over 300 facilities.

3.5 Outcomes Measured and Methods

In accordance with the study design, the following outcomes were measured:

- Number of new SDM users, total and trend over time
- Number of new users of other methods
- Percentage of all users who were SDM users
- Number of first-time FP users among SDM users
- Number of SDM users switching from other methods
- Number and proportion of SDM users continuing to use the method at time of interview
- Number of pregnancies among SDM users and percentage of users becoming pregnant
- Number and proportion of pregnancies by reproductive intention and correct/incorrect method use
- Perceptions of providers and programs managers on the burden/cost of introducing SDM services

Methods

Sources of information to measure the above outcomes included:

- Service statistics, at the facility level and from the monthly reports at the regional level
- Individual patient charts kept at the service delivery site (charts of a subset [total 786] of SDM users were reviewed some 12 to 13 months after the project started)
- Interviews with approximately 30 providers, managers, and supervisors
- Individual interviews (clients were interviewed following a standard questionnaire [See Appendix A]).

Individual interviews began in March 2004, 18 months after SDM services first became available. At the time, there were 1,254 women registered as having received the SDM; 1200 of them were located and interviewed.

3.6 Monitoring

Steps to Monitor Implementation

Monitoring visits were conducted by the local coordinator. After the initial round of training workshops was completed, the ISR local coordinator (a midwife) started scheduling and making visits to facilities with trained providers. Items he checked on included whether the method was actually being offered and provided to clients, availability of CycleBeads at the site, quality of services provided (using the KIT), whether promotional activities were being carried out, and if SDM clients were being reported in the MIS. The coordinator provided feedback and general guidance to providers and other clinic personnel. Initially he provided CycleBeads to some facilities that were running low; but providers soon began to systematically include CycleBeads along with other commodities and supplies in their monthly requests to the respective network warehouses.

Service statistics

ISR personnel monitored monthly reports produced by the San Martin DIRESA MIS. These included cumulative number of SDM clients at the regional level as well as at the network and facility levels. Initially the coordinator verified these against clinic registries. It soon became clear that this was unnecessary, as the monthly reports quite accurately reflected data from the sites.

4. RESULTS

4.1 Implementation

Some 103 providers from 63 facilities in two networks were trained in the first round of workshops. After approximately 18 months, Directors from adjoining networks were requesting technical support to include the SDM in their services. In consultation with the Regional Director, ISR and IRH facilitated a process by which experienced personnel from Lamas and San Martin networks provided training and other technical assistance to their peers from other networks.

When the project was about to conclude, DIRESA officials requested that it be extended, to allow for consolidation in the networks where the method had just recently become available. By the end of the project the SDM was available in most facilities of the department.

Table 1. Facilities with Trained Personnel and SDM Services Available

Network	Micro net.	Number and Type of Facility				Facilities	Providers
		Reference Hospital	Rural hospital	Health center	Health post		
Tarapoto area		2				2	26
Rioja	7	1	1	4	36	42	50
Lamas	2	0	1	0	6	7	38
San Martín	11	1	1	13	82	97	255
Picota	5	0	1	4	23	28	45
El Dorado	3	0	1	2	15	18	60
Bellavista	6	0	1	3	23	27	58
Huallaga	3	0	1	3	14	18	60
M. Cáceres	5	1	0	4	28	33	62
Tocache	5	0	1	2	28	31	51
Total	47	5	8	35	255	303	705

Source: ISR 2004 /San Martín DIRESA-2002

4.2 Number of Users, Trends in Number of Users

Number of SDM clients

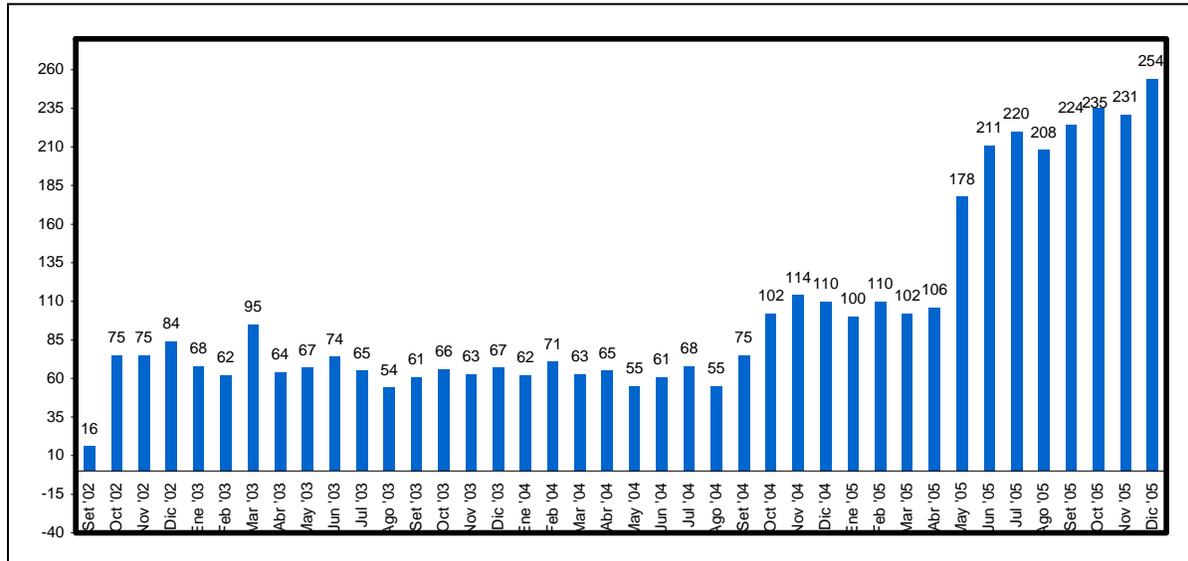
An approximate total of 4130 women had received SDM counseling by August 2005, 36 months after the method first became available in San Martín. Although study activities ended in September of 2005, and activities of the pilot introduction project were completed in December 2005, DIRESA providers have continued providing the method. There were a total of over 8,200 reported SDM users by the end of 2007 (MOH through September 2007).

Trend in number of SDM users

The San Martín DIRESA reported 16 new SDM users for September 2002, the first month the SDM was available (at a small number of facilities, as training of providers was just getting started). The monthly number of users increased rapidly: there were 75 new SDM users in October of that year; the number remained more or less stable at around 60 to 70 new users per month for the next 24 months.

In mid 2004 neighboring networks requested to be included in the project, and the SDM became available in additional sites; this was reflected in an increase in the monthly number of new clients to 100 -110. Even more sites were added in late 2004 and early 2005 as more networks asked for TA to include the SDM in their services. In early 2005 local MIS personnel involved in supervision activities updated providers on procedures to register SDM users. As a result of these events, by the time the study concluded in late 2005 San Martín MIS was reporting some 220 new SDM users per month.

Figure 1. New SDM Users per Month Reported by San Martin DIRESA



Source: ISR 2005/ San martin DIRESA

The average number of new SDM users continued at approximately 220-230 per month after project activities were completed at the end of 2005, and has stayed in the same range through late 2007.

4.3 Effect on Demand for Other Methods

Most women who chose the SDM were not using another modern method at the time. The largest group was that of women who reported they had stopped using calendar rhythm (59% of them because they considered it unreliable) to start the SDM. While most of them had used other FP methods in the past, almost all of them had stopped using a method some time before choosing the SDM. The exception to this trend were those who reported they had stopped using oral contraceptives (over 96% of them because of side effects) less than one month before starting the SDM.¹²

¹² ISR, 2004.

Table 2. Method Used Before Choosing SDM

METHOD	Total	Time between stopping previous method and choosing SDM		
		<1 month	1 - 3 months	> 3 months
None	16	14	2	
Oral	342	202	118	22
Injectable	211	71	74	66
Condom	31	17	13	1
IUD	45	26	13	6
Calendar	398	369	24	5
LAM	19	17	1	1
Other	1	1		
Total	1063	717	245	101

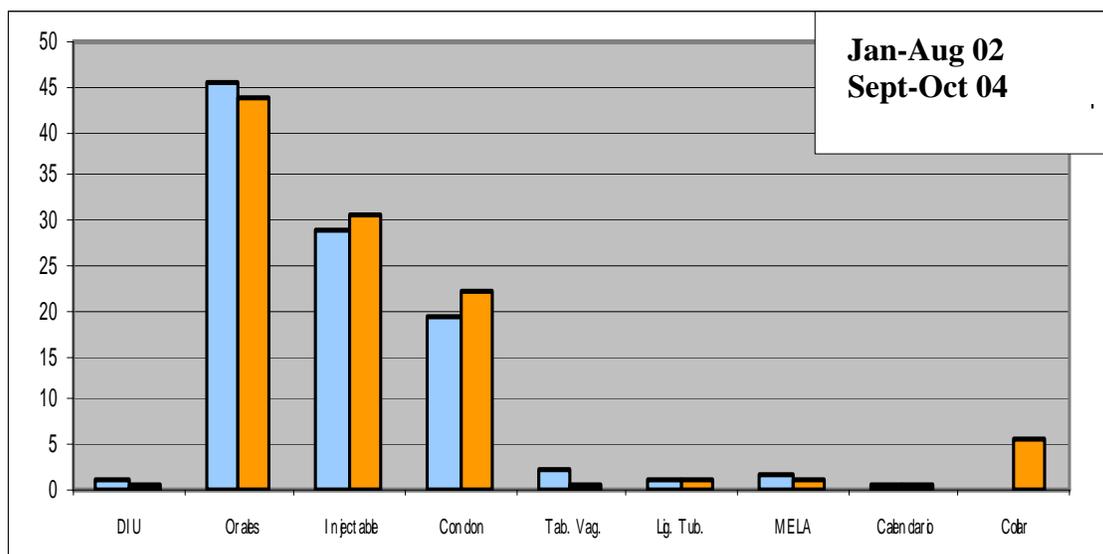
Source: ISR 2004

Distribution of users by methods

The proportion of users of other methods did not change significantly after the SDM became available in September 2002. Oral contraceptives remained the method chosen by more women, followed by Depo Provera® and condoms.

By the end of the study, approximately 5% of all new users were choosing the SDM.

Figure 2. Proportions of New Family Planning Users by Method



Source: San Martin DIRESA. Various monthly and quarterly report. 2002-2007.

4.4 Pregnancies

Pregnancies among SDM users

Some 105 SDM users (of 1200 interviewed) reported becoming pregnant while using the SDM. The largest group was those reporting that they had wanted a pregnancy and had used the method to become pregnant.

Table 3. Pregnancies Among SDM Users

Reason for Pregnancy (client-reported)	Number	%
Not Pregnant	1095	91.2
Planned pregnancy	42	3.5
Unprotected intercourse days 8-19	36	3.0
Protected intercourse days 8-19	14	1.2
Had experienced out-of-range cycles	5	0.5
Had stopped using method	1	0.1
Correct method use only	7	0.6
TOTAL	1200	100

Source: ISR 2004

4.5 Provider Workload

Providers reported that they did not consider the SDM to be an additional burden. Rather, they seemed pleased with it and considered an efficacious use of their time. Most frequent comments from providers on the topic of ease of providing the method to their clients included:

- clients learn the method easily;
- if providers explain the method carefully, clients are not confused, and the results are good.
- there is little need for follow up; MOH protocols require that all FP clients come for a follow-up visit. But providers report that when clients show up for their scheduled follow-up visit report they state that they do not have difficulties with the method, and they do not need much additional reinforcement.
- clients are happy with the SDM, so they do not discontinue (compared to hormonal methods, which women discontinue because of side effects or fear of complications).

5. DISCUSSION

All main questions posed by MOH decision makers were answered to their satisfaction. All four study hypotheses were proven correct.

Demand for the method

Demand for the SDM was sufficient to justify the effort and investment made by the San Martin DIRESA and its personnel. During the first months the method was available there were method-specific promotion activities, which could have contributed to the rapid increase in number of SDM clients. But numbers of new clients continued in the same range after promotional activities stopped. And there was a proportional increase in new clients when the number of sites with SDM services increased.

Effect on demand for other methods

A few months after the SDM became available, the number of SDM clients had stabilized at approximately 5% of all new FP clients. This figure remained stable for the duration of the project and after the project concluded. This allayed concern among some decision makers that large numbers of users of other methods would switch to the

SDM, or that overenthusiastic providers would promote only the SDM and stop offering other methods.

These results were confirmed by year-end MIS numbers that showed that numbers of users of other methods had not gone down, and that orals, injectables and condoms were still the methods chosen by more women, with more new users (chosen by 43, 31 and 22% of all new family planning users respectively).

Efficacy

Pregnancies among SDM users in San Martin did not exceed the proportion of pregnancies seen during the efficacy trial. Although the data did not allow for life table analysis, the number of pregnancies (in total, less than 9% of all SDM users, with the largest group being those who planned to become pregnant and used the method to achieve it) was comparable to figures from the efficacy trial, even when accounting for a possible underreporting in the number of pregnancies and possible incorrect reporting of fertility intention at the time of becoming pregnant.

Provider Workload

Providers and clinic directors involved in offering and/or providing the SDM did not consider the task to be burdensome. Most providers interviewed were satisfied with the method, mentioning it was easy to provide, did not require much follow up and that clients tended to continue using it (many compared this to the high discontinuation figures for hormonal methods).¹³

6. ADDITIONAL FINDINGS

Additional findings from the study include:

- The most frequent source of initial information on the SDM was radio spots, followed by word of mouth and informational talks in clinic waiting rooms.
- While in about half of cases (50.4%) it was the man who chose the SDM, 88% of users received the counseling by herself.
- The most frequent reasons for discontinuing the SDM were cycles outside the 26-32 days range (31% of discontinuers) and wanting to become pregnant (14%).
- Of those who discontinued the SDM for reasons not related to pregnancy, most switched to another modern method (55% to oral contraceptives, 37% to Depo Provera. Only 4% switched to the calendar method (compared to 37% of all SDM users whose most recent method before the SDM had been calendar).¹⁴

7. LIMITATIONS OF THE STUDY

The biggest limiting factor was that the study was superimposed on a project designed specifically to show that results in non-study settings would be similar to those obtained in the clinical trial. This political reality imposed important limitations on the type of data

¹³ ISR, 2007.

¹⁴ ISR, 2004.

that could be collected, the frequency of collection and the type of monitoring that could be done. It was not feasible to interview clients when they first received the SDM or to follow them periodically. Information obtained from the clinical charts was very incomplete, sometimes impossible to interpret. All information provided by clients came from the individual interviews and was retrospective. This may have led to underreporting of events, including pregnancies, and/or to inaccurate recollection.

8. RESULTS BEYOND THE PILOT INTRODUCTION

As a result of examining preliminary and final results of the pilot introduction in San Martin, MINSA decision makers agreed that the SDM could be a good option for MOH programs, and authorized ISR and IRH to work with other DIRESAS to include the SDM in services in those departments. MINSA officials facilitated the process for some of these DIRESAS.

Since then, the SDM has been included in the services of six other Directorates and is thus available throughout most parts of three other departments (Arequipa, Piura, Tumbes) and in the areas covered by three of five Directorates of the department of Lima (including the city of Lima, Callao province and most of the northern part of the department).

The situation in Peru is one in which MOH policy makers requested specific information to assist them in the decision making process, the information obtained was favorable to making the SDM available countrywide, and the MOH moved forward. However, it is not clear that the MOH will continue expanding SDFM services to additional departments without sustained external support.

Appendix A: Interview Questionnaire

FICHA DE LA USUARIA DEL MÉTODO DEL COLLAR

Usuaría # _____

Fecha de visita ___ / ___ / ___

Red : _____	1.	_____ - _____ - _____
Microrred : _____		
Establecimiento : _____		
1. Proveedor del método : _____	2a.	_____
Tipo de Proveedor : 1=Profesional <input type="checkbox"/> _____ 2=Técnico <input type="checkbox"/> _____	2b.	_____
2. Proveedor entrevistado : _____	3a.	_____
Tipo de Proveedor : 1=Profesional <input type="checkbox"/> _____ 2=Técnico <input type="checkbox"/> _____	3b.	_____

Datos generales de la usuaria

Nro. de Historia Clínica _____	4.	←
Edad _____	5.	←
#Hijos vivos _____	6.	←

Respecto al último método usado

Último método usado : _____	7.	_____
Lo dejó : 1=Sí <input type="checkbox"/> 2=No <input type="checkbox"/>	8.	_____
Cuando lo dejó : _____ / _____ / _____	9.	←
Porqué lo dejó : _____	10.	_____
Si es que no lo dejó , o sea aún continúa con el método anterior, explicar porqué:	11.	_____

Respecto al método del Collar

Fecha de inicio de uso del método _____ / _____ / _____	12.	←
Cómo se enteró del método _____	13.	_____

Con quién recibió la consejería:

1=Sola 2=Con el esposo ó pareja

14.

Estado actual (Marcar con aspa en el cuadro correspondiente)

(Fechas se refieren al día del abandono ó embarazo, **NO** es la fecha en que se enteró la obstetriz)

1. Nueva

2. Continuadora

3. Abandono

• Fecha de abandono ___ / ___ / ___

• Motivo _____

4. Embarazo

• Fecha de embarazo ___ / ___ / ___

• Motivo _____

(1=Nueva / 2=Continuadora / 3=Abandono / 4=Embarazo) 15.

(En caso de abandono o embarazo: fecha) 16. ___ / ___ / ___

(En caso de abandono o embarazo: motivo) 17. _____

Duración del ciclo menstrual

¿Hay información en la Historia clínica sobre la duración de sus ciclos?

1=Sí 2=No

18.

19. Si hay información, anotar lo escrito en la historia:

	Fecha de consulta	Información sobre ciclos (F.U.R, R/C, etc)
1.		
2.		
3.		
4.		

	Fecha de consulta	Información sobre ciclos (F.U.R, R/C, etc)
5.		
6.		
7.		
8.		

Respecto al Seguimiento

#De visitas de seguimiento

20.

21. Anotar sólo las **últimas** 10 visitas que figuran en la Historia Clínica:

Seguimiento	1	2	3	4	5
Fecha	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Seguimiento	6	7	8	9	10
Fecha	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___

22. Otras visitas **no formales** (anotar las 5 últimas):

	1	2	3	4	5
Fecha	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__

OBSERVACIONES