The Cost Effectiveness of Standard Days Method® Refresher Trainings using the Knowledge Improvement Tool in Guatemala

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The *Institute for Reproductive Health* 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 of 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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Executive Summary

Ensuring that family planning service providers have the necessary support to offer quality services is a challenge for program managers. Most programs do not have adequate resources to provide refresher training, follow-up and supervision to their service providers, which can result in poor quality of care. As the Institute for Reproductive Health at Georgetown University has worked with NGOs and ministries of health around the world to scale up the Standard Days Method® (SDM), a consistent challenge has been obtaining follow-up support for providers. To address this issue, the Institute developed an instrument called the Knowledge Improvement Tool (KIT), which allows supervisors to quickly identify gaps in knowledge of SDM providers, allowing them to provide targeted, effective support during routine supervisory visits.

Operations research has demonstrated the effectiveness of the KIT in improving and maintaining SDM providers' knowledge. However, in practice the KIT has been applied in different ways: individually, in group settings, and provider to provider. The objective of this study was to assess the cost effectiveness of these different approaches and compare it to taking no action at all. The study showed that follow-up is necessary and that the most cost-effective approach is the group KIT refresher training. Programs which already actively supervise service providers through an individualized approach should consider a similar strategy for SDM providers using the KIT, as this strategy yielded superior results in terms of provider competence.

LIST OF FIGURES AND TABLES

Acronyms

BCC	Behavior Communications and Change
DHS	Demographic and Health Survey
IEC	Information, Education, Communication
IRH	Institute for Reproductive Health
IUD	Intrauterine Device
KIT	Knowledge Improvement Tool
NGO	Non-governmental Organization
SDM	Standard Days Method
USAID	United States Agency for International Development

1. INTRODUCTION

The Standard Days Method® (SDM) is a fertility awareness-based method of family planning, developed by the Institute for Reproductive Health (IRH), Georgetown University. This natural method was developed to respond to the need for simple, accurate ways for women to recognize when they should avoid unprotected intercourse to prevent pregnancy. The results of efficacy trials showed that when couples used it correctly, the SDM was more than 95% effective[1]. The SDM is based on the fact that there is a "fertile window" during a woman's menstrual cycle - a window of days during which she can, with varying degrees of likelihood, become pregnant as a result of unprotected intercourse. For women whose cycles usually range between 26 and 32 days long, this window is from day 8 through day 19 (inclusive) of their cycles. Its use (and effectiveness) relies on avoiding unprotected intercourse during the fertile days of the woman's menstrual cycle.

Usually, upon completion of one- or two-day trainings, family planning providers are able to offer the SDM competently. However, it is widely recognized that knowledge decays over time after training. In addition to the initial training, new providers require refresher training and support, which can be costly and time consuming. Operations research conducted by the Family Planning Unit of the Ministry of Health (MOH) of Guatemala assessed the impact and cost-effectiveness of different supervision strategies for family planning providers. Research demonstrated that a self-assessment checklist to identify care-related problems and which served as the basis for future supervisory visits was the most effective in terms of improving provider knowledge and cost-effectiveness[2]. Another study in Kenya demonstrated that post-training, on-site supervision can improve quality of care. Researchers reported that their intervention resulted in significant improvements in quality of care at the supervisor, provider and client-provider interaction levels.[3]

Recognizing that SDM providers would need ongoing supervision and support, the Institute for Reproductive Health set out to develop an inexpensive approach for supervision. The result was a tool designed to both monitor and maintain knowledge over time known as the Knowledge Improvement Tool (KIT). The KIT guides family planning supervisors to ask the provider a list of questions, reinforce correct answers, and address any knowledge gaps (see Appendix A).

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[1] Arevalo M.; Sinai I.; Jennings V. Contraception, Volume 60, Number 6, December 1999 , pp. 357-360(4), Elsevier.

[2] Rosenberg R, Garcia M, Arroyo JJ, Staunton A, Vernon R. Using self-assessment to improve the family planning program of Guatemala. Operations research final report (Sub-agreement No. CI91.73A), September 15, 1991 - November 15, 1993. Prepared by Family Planning Unit / Ministry of Health and Public Assistance and INOPAL II / The Population Council.

[3] Reynolds HW, Toroitich-Ruto C, Nasution M, Beaston-Blaakman A, Janowitz B. Effectiveness of training supervisors to improve reproductive health quality of care: a cluster-randomized trial in Kenya. Health Policy and Planning. 2008 Jan;23(1):56-66.

The KIT has been used for the last few years in programs offering the SDM throughout the world, and evidence suggested that after two supervision visits, provider knowledge reaches and maintains an acceptable level. However, questions remained regarding the effectiveness of KIT compared to traditional forms of refresher training, such as group events which bring together several providers and a trainer for approximately two hours. This study was designed to compare the effectiveness and the cost benefit of KIT to other methods of reinforcing SDM provider knowledge. The hypothesis was that administration of KIT is more cost-effective than other methods.

2. THE SDM IN GUATEMALA

Guatemala is the largest country in Central America with a population of 12 million. Despite over thirty years of family planning programs in Guatemala, contraceptive prevalence remains stubbornly low, with just 43% women aged 15-49 in union reporting that they are using some form of contraception according to the 2002 ENSMI (DHS). Furthermore, contraceptive prevalence among the two target populations of this project is significantly lower than the national average. For women living in rural areas, prevalence drops to just under 35% and for indigenous women it falls even further to 24%. Of that figure, nearly 9% practice some form of natural family planning, although no more than 40% of periodic abstinence users could identify the midpoint of the cycle as the time when women face the greatest risk of pregnancy. This finding implies that more than half of the women that use periodic abstinence do not know the correct time during menstrual cycle when they run a high risk of pregnancy if they have unprotected intercourse.

Given these circumstances, there is a high level of interest in expanding access to family planning in Guatemala, and one of the strategies for doing so is expanding contraceptive choice through the integration of natural family planning in the method mix. The SDM is an important part of this strategy, IRH, at the request of the MOH and the Guatemala Social Security Institute (IGGS), has focused efforts over the last three years on providing technical assistance for scaling up access to the method on a national level.

IRH has been working to integrate the SDM into the family planning service mix in Guatemala since 2002 when it was included in the national contraceptive norms. Partnerships have been established with NGOs, the MOH and the IGGS. Activities have included trainings, information, education, and communication (IEC) and behavior change communications (BCC) campaigns and service delivery. As part of the effort to integrate the SDM into private sector services, IRH partnered with PROREDES, the United States Agency for International Development (USAID) funded network of NGOs that provides trainings to its member NGOs on the SDM. Over 350 providers from 12 PROREDES NGOs were trained. The KIT study was conducted with the support and participation of these organizations.

3. METHODS

This study takes a comparative approach, gathering data related to SDM knowledge among providers in Guatemala who received refresher training/support through the application of three different methodologies: KIT applied on an individual basis, KIT applied in a group setting, and a two-hour refresher training led by an SDM trainer. There was also a fourth group, which served as the control and received no refresher training. Participants were providers from 10 NGOs belonging to the USAID/Guatemala supported PROREDES network, which were trained by IRH in mid-2004 during a one-day training. All providers were trained within a two-month time span by the same trainer. The study was approved by Georgetown University's Institutional Review Board and was funded by a grant received by IRH from USAID.

Given the fragile nature of the community-based NGOs, it was not expected that all 356 providers who participated in the initial trainings would still be with their respective organizations nearly 18 months later. In addition, if they were, it was uncertain as to whether they would still be actively offering the SDM. To that end, a questionnaire was developed and applied to gather basic information, including the status of the SDM, from each of the participating NGOs.

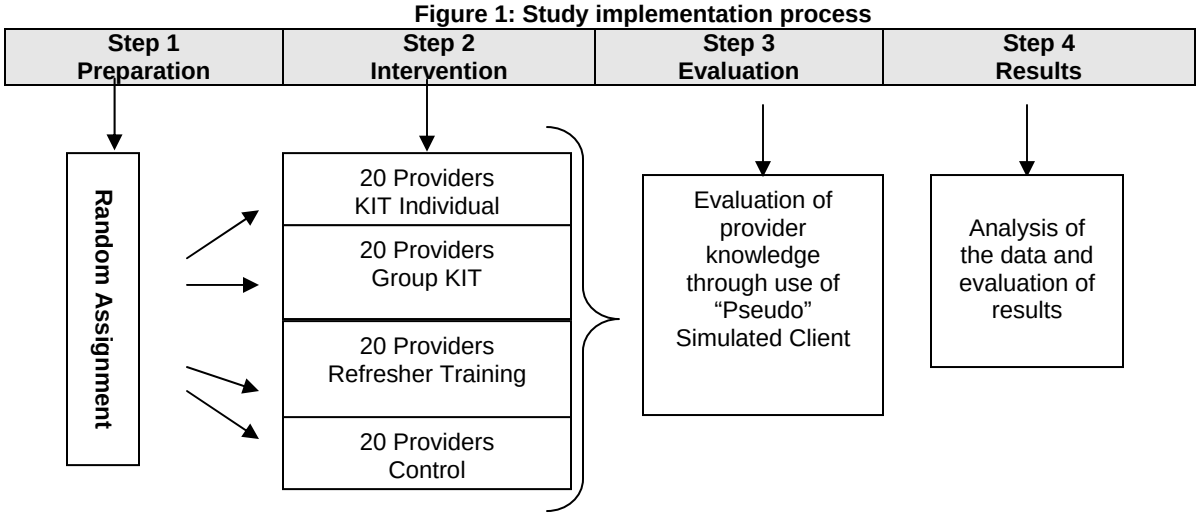
Invitations were extended to all providers, except for doctors, who were still offering the method to participate in the study. Doctors were excluded to keep the groups in the intervention at similar knowledge levels. The number of participants was limited to 80 for a number of reasons, including financial considerations, willingness to participate in the study, and the fact that many providers trained had never actively offered the method. Given interest in working with providers who had actively offered the method since training, virtually all participants were nurse auxiliaries and traditional birth attendants (comadronas). Of the initial 80 who were interviewed at baseline, only 60 participated in the simulated counseling session which constituted the endline. This was also due to budget constraints and logistic considerations. Participants were spread out over a large geographic area of the Guatemalan highlands, and visiting all 80 was not feasible.

The 80 providers were randomly assigned to four groups stratified by type and organization and designated as Groups A to D:

- Group A received an individual KIT refresher training
- Group B received KIT in a group setting
- Group C received a two-hour refresher training
- Group D was control and received no reinforcement

The following diagram depicts how the process of study implementation:

Figure 1: Study implementation process



Three months after the intervention, provider knowledge was evaluated through the use of *pseudo* simulated clients. This consisted of an observed counseling session during which trained women played the role of a client for whom the SDM is appropriate. This simulated client enacted the profile of a woman who knows the date of her last menstruation, is interested in using the SDM, and meets the eligibility criteria. The complete profile is included in Appendix B. The provider was given the job aids used in SDM counseling, including a set of CycleBeads®, to use during the simulated counseling session.

A trained observer observed the counseling and completed a checklist. The checklist covered all the key elements that are associated with quality SDM counseling, and essentially reflects the information covered in the KIT itself including couple communication, method eligibility criteria, sexuality, and how to use CycleBeads, the visual tool that supports SDM counseling and method use. As each item was addressed, or omitted, by the provider, the observer checks off a presence or absence on the checklist. This information was then entered into a spreadsheet for analysis.

In addition to gathering information on the effectiveness of each intervention, there was an interest in ascertaining the relative cost effectiveness of each approach. Therefore, cost data was collected for each of the three interventions. This consisted of the time required for the training/use of KIT, materials costs, and additional costs such as transportation venue. The total cost of each intervention was divided by the number of total participants in order to establish the cost per provider.

4. RESULTS

The PROREDES NGOs were spread out over several departments around Guatemala City and the highlands. In total 10 NGOs were trained in the SDM.

In addition to working on issues related to health and family planning, the NGOs had a variety of other programs including education, microcredit and agriculture. All were providing family planning services through clinic-based and/or community based-services. Methods offered included Depo, IUDs, condoms, and the pill. Providers included doctors, nurses, nurse auxiliaries, traditional birth attendants and community health workers. Given the large indigenous population in Guatemala, most of these NGOs had staff who spoke local languages in addition to Spanish, including Kakchiquel, Quiche and Mam.

An interviewer visited each of the PROREDES NGOs which participated in the training in order to establish what work, if any, they had done with the SDM during the 18 month intervening period. Given that funding for the PROREDES network had come to an end, there was some concern that these organizations were no longer engaged in providing any family planning and/or reproductive health services. The following table provides an overview of some the responses of the organizations' respective family planning coordinators to the questionnaire.

Question	Respondents Yes	Respondents No
Does your organization still offer family planning?	8	0
Does your program offer the SDM?	4	4
Do you intend to offer the SDM in the future?	7	1
Do you have CycleBeads?	5	3

Of the ten participating organizations, the interviewer succeeded in speaking with eight program managers. All reported that they continued to offer family planning. They also indicated a strong interest in working with the SDM. Those organizations which were not offering SDM services requested support in the form of follow-up training, promotional materials, and CycleBeads.

As noted, of the original 80 providers, 60 participated in the observed simulated counseling session. The report provides information on the 60 individuals from endline and cost data are available. The following table provides a breakdown of the number of providers, by type, from each organization included in the study.

Table 1: Study participants by type and organization

NGO	# of Nurses	# of CBDs	# of Midwives	Total
ADISS		17		17
ADEMI		1		1
PRODESCA		3		3
Renacimiento	3	1		4
Caroll Bertholl		5		5
CORSADEC		10		10
Codecot			20	20
Total	**3**	**37**	**20**	**60**

Table 2 shows the distribution of each type of provider within each intervention group. The differences in the percentages of the participants of each type was non-significant between intervention groups ($p>0.05$).

Table 2: Distribution of provider type within each intervention group

Intervention Group	# of Nurses	# of CBDs	# of Midwives	Total Number
Individual KIT	1	11	3	15
Group KIT	1	8	6	20
Traditional Refresher	1	10	4	15
No Refresher	0	8	7	15

The table below shows the average percent of key elements covered by providers in each intervention group. Those key elements are subdivided into three categories of competency: client needs assessment, contraindications, user instructions, follow up, and use of support materials. The totals were computed by two methods: the average for each of the previously-named subsections and the average for each checklist item. The category average assumes that each category is equally important for quality counseling. However some categories contain fewer questions, and thus some checklist items are given more weight. The checklist item average gives equal importance to each item, but would give more weight to categories with more checklist items.

Table 3: Average percent of key elements covered during counseling by intervention group

	Number of Questions	Individual KIT	Group KIT	Traditional Refresher	No Refresher
Number of Participants		15	14	15	15
Client Needs Assessment	6	84.4%	77.4%	78.9%	40.0%*
Contra-indications	10	84.0%	81.4%	78.0%	46.7%*
User Instructions	10	90.7%*	79.3%	82.7%	44.7%*
Follow-up	6	72.2%	70.2%	70.0%	30.0%*
Use of Support Materials	4	65.0%	55.4%	58.3%	46.7%^
Total (average of categories)	**36**	**79.3%**	**72.7%**	**73.6%**	**41.6%***
Total (average of each question)	**36**	**81.9%[@]**	**75.4%**	**75.9%**	**42.2%***

* significantly different from all other intervention groups at p<0.01
^ significantly different from individual KIT at p<0.01 and traditional refresher at p<0.05
[@] significantly different from group KIT at p<0.05

The sample sizes for these intervention groups is very small; only 15 forms were received for each group. Thus, the significant results strongly suggest that some type of refresher is definitely needed. Of the type of refreshers, individual KIT would be the best due to the significant difference in the “user instructions” sub-score.

There were problematic areas in all groups as observed at the simulated counseling session related to partner issues, counseling, and use of tools. It appears that the provider did not:

- offer to talk to the partner,
- offer to explain how to use a condom,
- give the client condoms,
- refer to the job aids to explain the SDM, or
- use any other tools.

Table 4: Costs by category of each intervention

Intervention	Time of Trainer (GTQ)	Cost of Materials	Refres-hments	Participant Transport.	Venue	Other (including trainer transportation and food)	Cost per provider	Total Cost
Individual KIT	$424	$411	$0	$0	$0	$1,975	$141	$2,810
Group KIT	$65	$46	$68	$296	$43	$42	$28	$561
Traditional Refresher	$49	$39	$101	$205	$43	$40	$24	$477
No Refresher	$0	$0	$0	$0	$0	$0	$0	$0

The individual KIT is the most costly of all refresher methods because of the time and travel of the supervisor/trainer. Group KIT and traditional refreshers cost about the same amount. Supervision, while critical to ensure quality services, is very expensive and is something which is often overlooked in program planning and budgeting. Programs must consider what is most practical in terms of existing supervision systems and their respective budgets. Program planners should be aware that if KIT is integrated into individual supervisor's work plans, it may not occur in reality, and thus other strategies may be required.

5. DISCUSSION AND IMPLICATIONS

These results suggest that some type of refresher training is essential for the sustained capacity of SDM providers. Without refresher training, knowledge of providers is below the minimum level accepted for SDM providers (60%). The individual KIT is the optimum approach, but requires much more resources for limited added benefit. Therefore, individual application of KIT is primarily appropriate for programs that already conduct individual site visits and can therefore integrate KIT into their routine supervisory visits. Programs that do not already include individual site visits could consider either group KIT or traditional refresher trainings. Group KIT and traditional refresher trainings produce similar results, with the group KIT approach being slightly less expensive.

Appendix A

NGO information questionnaire
Información de Servicios del MDF de las ONGs de PROREDES

1. **Información general sobre la organización:**

   - **Nombre de la organización: _____**
   - **Área/Sitio de cobertura: _____**
   - **Servicios de planificación familiar y métodos ofrecidos: _____**
   - **# de personal que brindan PF/servicios: _____**
   - **# de personal comunitario que brindan información/servicios: _____**
   - **Numero de clínicas o sitios: _____**
   - **Idioma(s) principal de la población: _____**
   - **Enfoques principal es (salud, agricultura, micro-empresa, etc.): _____**

2. **Todavía esta ofreciendo métodos de planificación familiar? _____ Si no, por que? _____**
3. **Participa en el programa de extensión de cobertura? _____**
4. **Capacitación en el MDF:**

Fecha de Capacitación	# de personal clínico capacitado	# de personal comunitario capacitado	# total de personal capacitado	Nota/Comentarios

5. **Proveedores:**

# de personal clínico activo*	# de personal comunitario activo*	Comentarios

**Nota: "Activo" significa que sigue reportando usuarias de PF aunque no tiene que tener usuarias del MDF*

6. **Supervisión o refrescamiento**
   a.) Ha replicado la capacitacion de Belejeb Batz? _____
   Como/Donde? _____
   b.) Que tipo de supervisión/monitoreo de los proveedores ha realizado? _____
7. **Servicios**

Appendix A

Período de Reportaje	# de Usuarias de todos métodos*	# de usuarias del MDF	# de sitios que ofrecen el MDF	Comentarios

* Anexar datos si disponibles

8. Logística

# de collares dotacion	# de collares en stock	Formulario de Registro de Usuarias (si o no)	Comentarios

9. IEC

Material o Actividad	Si o No?	Numero	Si disponible, durante que periodo?	Comentarios
Charlas comunitarias				
Charlas en servicio				
Visitas domiciliarias				
Afiches				
Volantes				
Otro:				

10. Planea seguir brindando el MDF? _____
Si no, por que: _____

11. Necesita algún apoyo?
Materiales de IEC_____
Collares_____
Capacitación _____
Otro _____

Comentarios:
_____
_____
_____
_____

Annex B

Pseudo Simulated Client Profile and Checklist
Instrucciones para la observación de la clienta seudo simulada:

En vez de aplicar el KIT a cada uno de los 80 alumnos que están participando en el estudio, vamos a observar una consejería simulada. Puesto que no hay tanta demanda para el método e ir a cada centro seria muy difícil la idea es observar una consejeria simulada en la cual alguien se va a actuar como si fuera una usuaria de servicios de planificación familiar en un centro de servicio.

De preferencia usted tendrá un equipo de 2 o 4. Una persona jugara el rol de usuaria y la otra será la observadora. Si logra tener un grupo de 4, se puede tener dos grupos de dos y asi pueden terminar más rápido. Si solo van a haber dos (1 usuaria y 1 observadora) y hay un grupo de 20, tal vez quiere avisarle a los participantes que no tienen que llegar a la misma hora. Un grupo de cinco podría llegar a las 8 am, el segundo a las 9, etc.

La persona que va a jugar el rol de usuaria debe familiarizarse con su perfil de usuaria. No se debe necesita referirse a la hoja durante la sesión. Asimismo, la observadora debe saber el contenido de la lista de chequeo para que sea fácil llenarla durante su observación de la consejeria. Es importante que usted hable con las otras observadoras antes de la actividad para asegurarnos que estén interpretando y anotando todo aplicando los mismos criterios.

Usted debe darle a la usuaria simulada una fecha de su última menstruación, para que el proveedor pueda determinar que la duración de su ciclo sea apta para usar el método. Puesto que el perfil nota que la usuaria esta en el sexto día de su ciclo, la fecha que se usa debe ser 5 días antes. Lo que sigue es el perfil de la usuaria, note que la usuaria llega a clinica ya decidida que quiere usar el collar:

- Es esposa de un comerciante
- Dice que quiere usar el collar
- Termino la secundaria
- Tiene 25 años de edad, dos hijos (4 años y 11 meses)
- Esta amamantando su bebe en estos momentos
- No ocurre violencia intra-familiar
- Usó el método del ritmo (quedo embarazada)
- Quisiera tener mas hijos en el futuro
- Hace 5 meses que volvió la menstruación
- Su menstruación le llega cada mes mas o menos alrededor de la misma fecha (aproximadamente cada cuatro semanas)
- Quiere escoger un método anticonceptivo

- Tiene miedo a los efectos colaterales de los métodos hormonales
- Tiene miedo a que le inserten algo adentro

- Esta en el 6o día de su menstruación
- Durante los días fértiles practicará la abstinencia o usará condones
- Su esposo esta dispuesto a evitar relaciones o usar condón durante los días fértiles
- Su menstruación casi nunca llega antes o después de cuando la espera
- Sabe la fecha de su última menstruación

La proveedora debe responder a la situación como si fuera una consejería verdadera. La observadora tendrá una lista de chequeo a la cual se puede referir durante la consejería para determinar si la proveedora ha abordado todos los temas necesarios. La observadora debe dejar las ayudas (materiales de apoyo) sobre la mesa o el escritorio para que las proveedoras los pueda usar si le interesa.

1	**Área**				
2	**Departamento**				
3	**Municipio**				
4	**Nombre de Institución**				
5	**Fecha de Observación:** _____				
6	**Tipo de proveedora:** _____				
Instrucciones para los siguientes ítems Por cada ítem, conteste la pregunta, ¿Se dio en la consulta? Circule uno de los números de la derecha, que significan: Sí = 1, No = 0, o No recuerda = 99.					
Nº	**Diagnóstico de necesidades –Me preguntó:**		**Sí**	**No**	**NS/NR**
7	Si tenía hijos		1	0	99
8	La edad de mi último niño		1	0	99
10	Sobre los métodos que he usado en el pasado		1	0	99
11	Si ya tenía un método específico en mente		1	0	99

12	Si podría estar embarazada (menstruación, otras)	1	0	99
13	Si mi pareja colabora en planificación familiar	1	0	99
Nº	**Contraindicaciones – El proveedor preguntó:**	**Sí**	**No**	**NS/NR**
14	Si mi pareja aceptaría el Método del Collar	1	0	99
15	Si yo y mi pareja podríamos evitar relaciones sexuales o usar un condón durante los días fértiles	1	0	99
16	Si he tenido tres ciclos o cuatro reglas desde que nació mi bebe y la ultima tuvo una duración de 26 a 32 días	1	0	99
17	Si mi regla viene más o menos cuando la espero	1	0	99
18	La fecha de mi última regla y cuando espero la próxima	1	0	99
19	Si yo y mi pareja estamos en riesgo de ETS/tiene otras parejas	1	0	99
20	Si he usado la píldora en último mes	1	0	99
21	Si he usado el inyectable en los últimos 3 meses	1	0	99
22	Si puedo comunicar con mi pareja sobre cuando tener relaciones	1	0	99
Nº	**Instrucciones de Uso - El proveedor me dijo:**	**Sí**	**No**	
23	Que tiene que mover el anillo negro a la perla roja el día que comienza su regla	1	0	99
24	Que se debe marcar el primer día de mi regla en su calendario	1	0	99
25	Que las usuarias del Collar tienen que mover el anillo negro todos los días	1	0	99
26	Que se tiene que mover el anillo negro en la misma dirección	1	0	99
27	Que se debe averiguar con el calendario si se le olvida mover el anillo	1	0	99
28	Que las perlas cafés representan los días en que se puede tener relaciones sin protección	1	0	99

29	Que debo conversar con mi pareja sobre como evitar relaciones sin protección en los días fértiles	1	0	99
30	El proveedor ofreció explicarme como usar un condón	1	0	99
31	Que las perlas blancas representan días en que se debe abstener o usar condones	1	0	99
32	Que un embarazo es probable si tiene relaciones sin protección en un día fértil	1	0	99
Nº	**Seguimiento - El proveedor:**	**Sí**	**No**	**NS/NR**
33	Ofreció hablar con mi pareja	1	0	99
34	Me entregó un Collar y un calendario	1	0	99
35	Me entrego un condón	1	0	99
36	Me dijo que si no me baje su regla después de la ultima perla café, debo regresar al centro	1	0	99
37	Me dijo que si mi regla viene antes de llegar a la perla oscura, debo regresar al Centro	1	0	99
38	Me invito a volver si tenia preguntas	1	0	99
Nº	**Uso de Herramientas de Apoyo**	**Sí**	**No**	**NS/NR**
39	Usó el collar para explicar el método	1	0	99
40	Refirió al calendario para calcular la duración del ciclo	1	0	99
41	Refirió a las ayudas de proveedor para explicar el Método del Collar	1	0	99
42	Usó otras herramientas ¿Cuáles? Explica:_____	1	0	99

Comentarios:

_____
_____
_____
_____