

# Engaging Men in Family Planning Services Delivery: Experiences Introducing the Standard Days Method<sup>®</sup> in Four Countries

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## **Abstract**

Family planning is often regarded as the woman's responsibility, but there is growing recognition of the need to involve men in family planning programs. Since 2001, the fertility-awareness-based Standard Days Method<sup>®</sup> (SDM) has been introduced in more than 30 countries, providing a natural, effective birth control option. SDM requires the cooperation of the male partner, and its introduction created an opportunity to test innovative strategies to engage couples in family planning. Such strategies included couple counselling, outreach activities that encouraged men to participate in family planning and integration of family planning into traditionally male programs. Due to the SDM's intrinsic characteristics as a couple method, SDM providers are sensitized to the importance of exploring other critical sexual and reproductive health topics, including intimate partner violence, HIV, sexuality and partner communication. This paper presents several case studies describing how men were engaged in SDM introduction activities in four countries.

## Background

Family planning has traditionally been viewed as the woman's responsibility, but there has been a growing recognition of the need to involve men in family planning programs as a means of achieving reproductive health objectives, as well as attaining greater gender equity. The 1994 International Conference on Population and Development (ICPD) in Cairo made an explicit call for programs and policies to educate and enable men to play a more active role in reproductive decisions, including contraceptive method choice and use (Boender et al. 2004; Gribble 2003). Since the ICPD, this more expansive, gendered perspective on the goals and mandates of family planning programs has led to the design and implementation of a range of strategies to involve men in family planning service delivery.

Simultaneously, the proliferation of new contraceptive technology has increased the range of family planning options available to men and women around the world. However, since the method mix is dominated by female methods (such as the patch, implants, injectables or oral contraceptive pills), their mere availability has not automatically supported the broader goal of involving couples in family planning services and decisions. The introduction of the fertility-awareness-based Standard Days Method® (SDM) in 2001 created an opportunity to simultaneously test innovative strategies for engaging men in family planning service delivery, as well as to promote male participation in contraceptive use. Developed by Georgetown University's Institute for Reproductive Health (IRH), the SDM is a method that entails avoiding unprotected sex during a woman's fertile phase of her menstrual cycle. Unlike the rhythm method, SDM is a modern method that has been tested in rigorous efficacy trials, yielding a typical use effectiveness rate of 88%. SDM is appropriate for women whose menstrual cycles range from 26 to 32 days; SDM users avoid unprotected sex on days 8 to 19 (Arévalo et al. 2002). To help couples monitor cycle length and identify fertile days, IRH also developed a mnemonic device (CycleBeads®) consisting of a strand of colour-coded beads that correspond to fertile and "safe" days. SDM has been introduced in 30 countries and is included in the family planning norms in 16 countries; the World Health Organization recognizes it as an effective, modern method (Gribble 2003).

The overall aim of this paper is to present case studies of how couples have been engaged in efforts to integrate SDM into a variety of programs, and to explore the impact of those strategies on reproductive health and gender outcomes of interest. We begin with a broad overview of the extant literature on male involvement in family planning. Next, we synthesize relevant project reports and peer-reviewed articles to describe initiatives to involve men in SDM introduction activities in El Salvador, India, the Philippines and Guatemala.

## Male Involvement in Family Planning

One strategy for involving men in family planning decisions has been to provide counselling and education to couples rather than just to women. In a review of published studies on family planning interventions aimed at couples, Becker (1996) found that in most cases, couple interventions were more effective than those aimed just at women in terms of family planning outcomes such as contraceptive use or continuation, pregnancy or abortion. A 2007 evaluation of couples' sexual and reproductive health educational sessions in Los Angeles and Oklahoma City found that participants in the intervention had more positive attitudes about partner participation in contraceptive use, compared to those in the comparison groups (Kraft et al. 2007). However, recognizing the potential financial and logistical difficulties of offering counselling to men and women at the same time, family planning programs have also employed a host of other innovative strategies to engage men. These include the use of male providers or health volunteers, extended service hours to accommodate men's work schedules, behaviour change communication (BCC) activities promoting male participation in family planning, provision of family planning information and services in traditionally male settings, and offering gender sensitivity training to providers (Boender et al. 2004; Rottach et al. 2009; United Nations Population Fund 2003). Even in those cases where the male partner is not directly targeted by services, there are other ways to engage him, both directly and indirectly. For example, the California Male Involvement Program reached men and boys by offering sexual

and reproductive health educational sessions in alternative/continuation and mainstream schools, juvenile detention centres and migrant work camps (Brindis et al. 2005).

The various outcomes of interest for these interventions range from pregnancy and contraceptive prevalence (i.e., demographic goals) to spousal communication and gender-equitable attitudes. For example, in a pre-ICPD study, Terefe and colleagues (1993) compared modern contraceptive use among Ethiopian couples receiving family planning home visits with and without husband participation, concluding that at the 12-month follow-up, couples in the husband-participation group were nearly twice as likely as those in the wife-only group to be using modern contraception. More recently, in a randomized study testing the efficacy of using “male motivators” to encourage family planning in Malawi home visits, Shattuck and colleagues (2011) found that the pre–post increase in contraceptive use was greater in the intervention arm than in the comparison arm.

The interventions introducing SDM involved men in family planning services by using a number of innovative strategies to improve family planning attitudes (including gender attitudes), increase contraceptive knowledge and bolster intra-spousal communication. The following sections describe four SDM introduction projects that involved men from both the supply side (e.g., training male volunteers as community health workers) and the demand side (e.g., targeting men in BCC campaigns).

### **Male Involvement in SDM Introduction Projects**

Between 2001 and 2006, IRH implemented SDM introduction projects that took a variety of approaches to involving men in family planning. A description of these projects is presented below, along with descriptions of how we attempted to assess the interventions’ impact on outcomes of interest.

#### **Promoting Men’s Interest in Family Planning in Rural El Salvador**

Building on previous pilot projects demonstrating the potential effectiveness of involving men by integrating family planning into non-health activities, between 2001 and 2002, IRH collaborated with Project Concern International (PCI) to introduce family planning content into PCI’s “male friendly” water and sanitation program in El Salvador. Specifically, in 13 rural villages with existing water and sanitation projects, project staff trained PCI volunteers and staff to add family planning to ongoing health education group talks, underscoring the relationship between fertility and sustainability of natural resources. The intervention also consisted of two home visits by PCI volunteers, the first of which covered the relationship between natural resources and health, as well as the benefits of family planning and joint decision making as a couple. The second home visit, which took place a week later, covered fertility awareness, the menstrual cycle and family planning methods (including SDM). To increase access to men who worked during the day, PCI volunteers went to fields to reach men during work hours and also conducted meetings in the evenings and on weekends. In addition, IRH worked with the Comité de Integración y Reconstrucción de El Salvador (CIRES) to train its network of community volunteers to add family planning (including SDM) to its service offerings in 24 rural communities. CIRES volunteers conducted household visits and, for couples who opted for SDM, returned for follow-up visits after the first cycle and then after every third cycle for up to 13 months.

As discussed by Lundgren and colleagues (2005), one of the strategies for evaluating the feasibility and impact of this intervention was to conduct baseline (n=341) and endline (n=364) household surveys in the study areas. An analysis of these data revealed that men who had participated in the intervention had significantly higher knowledge levels regarding male fertility and contraceptive methods, compared to non-participating men. Specifically, at follow-up, men demonstrated a significant increase in understanding about male fertility, with 80% of participants understanding that men are always fertile (as opposed to having cyclic fertility as women do), compared to 65% of non-participants. Furthermore, 65% of participants had heard of injectables, compared to 50% of non-participants; 18% were aware of the IUD, compared to 6% of non-participants; and 30% of participants were aware of SDM, compared to 7% of non-participants. In the endline survey, 29% of respondents stated that they had received a household visit from a provider, and of those, 25% of the visits were just with men, 33% with just women and 40% with the couple together.

The research team also conducted a prospective study of 143 SDM users, which consisted of an admission interview, a follow-up visit after one cycle, and then subsequent follow-up visits every three cycles for up to 13 cycles. Family planning knowledge improved over the course of the intervention, and at the end of the study, 138 (95%) of the participating men reported that they had received SDM counselling from various sources. The most common sources of SDM information were their wives (44%) and a provider (40%), followed by community volunteers (11%). The fact that a plurality of men reported that their wives informed them about SDM is a testament to the fact that male involvement does not necessarily need to consist of direct consultation with a provider (Lundgren and Monroy 2006).

In terms of the project's impact on intra-spousal communication, in interviews and focus group discussions, health promoters and community volunteers described the increased acceptability of discussing family planning, and that men were more engaged in the conversation. For example, a CIRES health promoter reported:

First we speak just to the woman; later we talk to them both, so the wife has already mentioned it to him. You arrive with their trust because the wife says to the husband, "This and that is what the CIRES promoters explained to me," so when we arrive it is not a surprise, and they already are expecting us. (Lundgren and Monroy 2006: 72)

According to the household survey data, overall contraceptive use increased across non-participants and participants alike, from 45% at baseline to 58% at endline. Among men, reported contraceptive use increased from 44% to 63%. A notable finding from the SDM user study is that users who had been counselled as a couple had fewer pregnancies compared to those whose husbands heard only part of the counselling or who had been informed only by the wife. Of the 17 women who got pregnant during the study, based on exit interviews at the time of pregnancy, just three had husbands who had participated fully in the SDM counselling. Although the number of pregnancies was small, given that 16 of the 17 were due to incorrect SDM use, this finding suggests that male participation in the counselling could promote correct method use (Lundgren and Monroy 2006).

### **Promoting Family Planning with Male Volunteers in Uttar Pradesh, India**

To test the feasibility of involving men in the introduction of SDM in rural villages in the Sitapur district of Uttar Pradesh, IRH collaborated with CARE India on an operations research study that compared a woman-focused model (in which female volunteers provided family planning information to residents) to a male involvement model (in which male and female volunteers provided counselling). CARE organizers trained female community volunteers to lead monthly educational meetings with groups of women, describing the different available family planning methods and introducing SDM. Male volunteers led similar meetings with both women's and men's groups. Both male and female volunteers also did home visits to clients to review instructions for use, check that the band was on the correct bead and the calendar was marked correctly (or check whether women were tracking their menstrual cycle correctly), and reinforce the couple's efforts to avoid unprotected sex on the fertile days. In both models, the volunteers provided counselling to women, men and couples when possible. During the two-and-a-half year study period, the woman-focused model was implemented in 24 villages (i.e., the Khairabad block) and the male involvement model took place in the remaining 24 villages (i.e., the Misrikh block).

In a prospective study of SDM users, 482 couples participated across the Khairabad and Misrikh blocks. In Misrikh, where male volunteers were active, 40% of men received SDM counselling from a female volunteer and 40% were counselled by a male volunteer. This is in stark contrast to the reported source of SDM information among Khairabad men, of whom 88% learned of the method from their wives. In interviews and focus groups with men, those in the Misrikh block felt they understood SDM better since it was explained by male volunteers (Das and Nandan 2004). The use of male volunteers to provide SDM counselling successfully reached men in the experimental villages, increasing their knowledge of a new natural family planning method.

Male volunteers also appeared to succeed at improving attitudes about family planning and men's roles in reproductive decision making. In the Misrikh block, among SDM users, nearly twice as many men would recommend the method, compared to those in the female-focused block (Johri et al. 2005). Furthermore, the qualitative assessment of SDM users' experiences suggests that male providers helped to reduce male opposition to family planning, since both users and providers felt that men were more comfortable discussing sexual issues with other men.

Qualitative research also suggests that intra-spousal communication was facilitated by male volunteers. Interviews with SDM users indicated that male cooperation was more evident among SDM users from the experimental block (Das and Nandan 2004).

Finally, male volunteers may have played a role in encouraging SDM continuation over the course of the study. Among SDM users, continuation rates were higher among the experimental group compared to the female-focused group, although the differences were only significant starting at seven months follow-up (Johri et al. 2005). In addition, the rate of incorrect SDM use was lower in the Misrikh block (0.3%) compared to the Khairabad block (2.6%), which is reflected in the higher pregnancy rates observed in Khairabad (18.8%) compared to in Misrikh (11.9%) during the follow-up period (Johri 2005). Involving men in SDM services was also a priority in the villages where men were not trained as outreach workers. Men were involved by conducting village meetings with men to orient them on the SDM and by training providers to talk to women about how men influence their use of family planning.

### **Using Men and Couples as Reproductive Health Educators in the Philippines**

In Bukidnon province in the Philippines, IRH introduced SDM in the ongoing reproductive health activities of the Kaanib Foundation, a local non-governmental organization (NGO) that works with subsistence farmers and agrarian reform beneficiaries. In addition to testing the feasibility of teaching Kaanib's male members how to use SDM, the operations research study consisted of testing two strategies to increase male involvement on the supply side: one used couples as SDM counsellors, and the other used only men. The counsellors provided SDM education in their own homes as well as in the homes of clients.

According to a prospective study of 78 SDM users in the study area, SDM knowledge among those counselled by men was not significantly different from that of those counselled by couples (Institute for Reproductive Health/Philippines 2005). Throughout the follow-up period, more than 90% of SDM users were able to correctly explain how to use the method, demonstrating that both men and couples were effective at providing SDM counselling. Furthermore, significantly positive changes in reproductive health attitudes and husband–wife communication were observed among husbands in the intervention area, as reported by husbands and their partners (Rottach et al. 2009).

### **Involving Men in Family Planning in the Guatemalan Highlands**

In this male engagement intervention, IRH supported the promotion of SDM and fertility awareness through community development projects of the local NGO B'elejeb B'atz in the Altiplano region of Guatemala. The project launched with a number of BCC activities to increase awareness of family planning and SDM – including posters, radio spots and television interviews by NGO staff – that were designed with the input of men and with the objective of encouraging men to space their children, support their wife's use of family planning methods and participate in SDM use by using a condom, abstaining from intercourse on the fertile days or helping their wives to track their fertile days. IRH trained B'elejeb B'atz staff and volunteers on SDM, fertility awareness, the menstrual cycle, counselling and other contraceptive methods. To facilitate access to men, supervisors of micro-finance projects were incorporated into the project as family planning counsellors. In addition, the counsellors organized men-only educational talks that facilitated male participation in discussions on family planning. Furthermore, to facilitate conversation with men, female health promoters sometimes brought their husbands or older sons to community activities and household visits.

According to SDM user statistics, 51% of SDM clients had received counselling as a couple. Interviews and focus groups with male and female users as well as project staff and volunteers suggest that the intervention successfully engaged men in family planning. One of the male users stated, "If a man counsels me on family planning, he is practising what he preaches, and he wants me to say that it's not just the woman who should deal with this problem" (Suchi 2006: 52). Likewise, another male user remarked,

The supervisor has explained clearly to us that a man can help his wife with family planning, that he should not be ashamed for this; it's a natural thing. Even though he is a man, you can tell that he is very prepared for these talks. (Suchi 2006: 53)

### **When Men Are Not Present: Indirect Male Involvement in Family Planning and SDM Provision**

As stated previously, there are a variety of ways to involve men in family planning without necessarily requiring direct contact between the male partner and the service provider. In many settings, there may be significant logistical and cultural barriers to having men present at their partner's family planning counselling sessions. This section describes how SDM programs attempted to explore partner dynamics and address relationship issues related to family planning using strategies that did not require direct interaction between family planning services and male partners.

Across all SDM introduction settings, programs emphasized the importance of constructive male engagement in outreach efforts. In order to promote awareness of family planning and encourage male involvement in contraceptive decisions, targeted male involvement messages were included in posters, flyers, radio programs and wall paintings. For example, in Guatemala, IRH partners produced radio spots in local languages that emphasized the role of men in family planning and SDM. In family planning service delivery settings, when couple counselling is not possible or desired, providers trained on SDM can address relationship issues that influence family planning use with the woman alone, since the method's intrinsic characteristics as a couple method facilitate and encourage discussion of topics related to sexuality, such as partner communication, sexual autonomy, sexual pleasure, gender-based violence, alcohol use and STI/HIV AIDs, many of which are rarely addressed during family planning counselling. Thus, incorporating SDM helps programs explicitly address partner and sexuality issues in the context of method selection, method instruction, couple use of the method and follow-up. Research from India, for example, shows significant improvements in condom counselling after incorporating SDM into public sector programs. Similarly, data from Guatemala show that once providers began offering condoms as part of SDM instruction, they felt more comfortable offering it to all of their clients. SDM providers are particularly well positioned to address men and relationship dynamics because they have been trained to:

1. Assess whether the method will work well for the woman and her partner (including discussion of gender-based violence, sexual satisfaction, alcohol use and STIs, woman's autonomy to decide when to have sex);
2. Teach clients to use the method correctly, and consider the man's role in doing so; and
3. Help clients identify possible challenges they may face using family planning, and brainstorm to identify solutions.

Before providers have been trained to offer SDM, many have never given much thought to involving men in family planning; others think it is a fruitless or impossible task. Thus, one of the potential results of introducing SDM is the opportunity for providers to reconsider the paradigm that family planning services are for women only, and to help them reflect on the influence of social and cultural norms and power dynamics on fertility and family planning use.

### Conclusions/Recommendations

The SDM is a family planning method that is particularly amenable to involving men in its provision (from the service delivery perspective) as well as in its use. This paper describes various SDM service delivery strategies that engaged men, demonstrating that it is feasible to increase male involvement in family planning education and provision. Such strategies are likely applicable to all family planning methods, and offering SDM has helped to motivate providers to broaden the traditional female-centred paradigm for family planning services and programs. Furthermore, these operations research studies suggest that, compared to traditional family planning programs that solely address and engage women, interventions that involve men can lead to better outcomes in terms of attitudes about family planning and gender, family planning knowledge, intra-spousal communication, and family planning use and continuation.

As these projects demonstrate, male involvement strategies for family planning programs are not restricted to couple counselling, where the man and woman receive information and education at the same time and place. Although there are substantial benefits to counselling men and women together as a dyad (Greene and Levack 2010), couple interventions are not always appropriate or feasible, as was illustrated in some of the SDM introduction projects. For instance, if home visits are the foundation of a family planning intervention, it may be difficult to find a time when both the husband and wife are home together. Furthermore, providers who counsel couples must be adequately trained to ensure that both parties are willing to participate in a couple counselling session, and that both the man and woman share equally in the decision-making process. Otherwise, providers may run the risk of unintentionally reinforcing the man's dominant role or inadvertently displaying a bias toward either sex (Greene and Levack 2010). When couple counselling is not always possible, alternative approaches to involving men include men-only educational talks, male health promoters, BCC activities targeting men, and the integration of family planning content into non-health activities (such as agriculture and sanitation projects). Furthermore, providers can take care to address couples issues in counselling, even when only the female client is present.

There is a growing body of evidence that demonstrates that male engagement in family planning programs can improve both reproductive health and gender outcomes (Boender et al. 2004; Rottach et al. 2009). However, the rigour of the evaluations of these interventions is variable, and it can be difficult to distinguish between the effects of male involvement and the effects of the family planning intervention itself. This difficulty may be particularly acute in the case of the SDM, which is a method that requires male involvement. There remains a need for a strategic analysis of opportunities, advantages and disadvantages of involving men in various program elements, ranging from outreach and counselling to provider training. Nevertheless, this overview offers several examples of how we operationalized male involvement initiatives within the context of broader family planning introduction activities. These SDM projects may be useful models to inform future efforts to promote male involvement in the promotion of family planning more generally, integrated into activities promoting any contraceptive method. Furthermore, these case studies demonstrate the feasibility of engaging men in family planning interventions – as well as inherent challenges. Our hope is that this synthesis contributes to the growing experience base of public health practitioners, donors and healthcare providers seeking to involve men as equal partners with women in reproductive decisions.

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