



Introducing the TwoDay<sup>®</sup> Method  
to Experienced Natural Family  
Planning Providers in Africa

Submitted by:  
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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

The TwoDay Method<sup>®</sup> (TDM) is a fertility awareness-based method of family planning, developed by the Institute for Reproductive Health (IRH) at Georgetown University. This natural method relies on noticing the presence or absence of cervical secretions to determine whether or not a woman is fertile each day.

An efficacy trial found that the TDM was more than 96% effective with correct use and more than 86% effective with typical use. These effectiveness rates are similar to those of a number of other user-dependent methods<sup>1</sup>.

IRH piloted the TDM with two faith-based organizations (FBOs): Action Familiale Rwandaise (AFR) in Rwanda and Conduite de la Fécondité (CF) in the Democratic Republic of Congo (DRC) in August and September 2007 respectively. In Rwanda, IRH's Country Representative and the Director of AFR trained 18 female instructors working for AFR on the TDM from May 7 to 8, 2007. In the DRC, the Country Representative and the CF Director trained 14 instructors from June 25 to 26, 2007.

A one-day refresher training was held approximately one month after the initial training in Rwanda and three months after the initial training in the DRC to assess how well the instructors were able to use the method, answer questions, and reinforce concepts as necessary.

Focus groups discussions (FGDs) were conducted the same day as the refresher trainings. At the time, most providers had started using the method themselves and a few had begun offering it to clients.

The instructors participating in the focus groups demonstrated knowledge of the TDM and a theoretical ability to offer it; however, many of the participants had not yet had the opportunity to offer the method to clients.

Instructors who used the method (about half) found the method to be simple. Some believed that the TDM is easier for clients than the Billings Ovulation Method because women are more likely to notice the presence or absence of secretions rather than to be able to distinguish qualities of secretions. They also felt that the accompanying materials, such as the client card, helped simplify the method. They did not report any potential problems for integrating the TDM into their current programs. However, some providers disliked the fact that post-partum women must wait at least three menstrual cycles before beginning to use the TDM.

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<sup>1</sup> Hatcher R. et al. (2004). Fertility Awareness-based Methods. *Contraceptive Technology* 317-329.

## ACRONYMS

<b>AFR</b>	Action Familiale Rwandaise
<b>CF</b>	Conduite de la Fécondité
<b>DRC</b>	Democratic Republic of the Congo
<b>FBO</b>	Faith-based Organization
<b>FDG</b>	Focus group discussions
<b>IEC</b>	Information Education and Communication
<b>IRH</b>	Institute for Reproductive Health
<b>LAM</b>	Lactational Amenorrhea Method
<b>NFP</b>	Natural Family Planning
<b>NGO</b>	Non-governmental Organization
<b>SDM<sup>®</sup></b>	Standard Days Method <sup>®</sup>
<b>TDM<sup>®</sup></b>	TwoDay Method <sup>®</sup>
<b>USAID</b>	United States Agency for International Development

## **1. STUDY BACKGROUND**

### **1.1 Broad issue**

The TwoDay Method<sup>®</sup> (TDM) is a fertility awareness-based method of family planning, developed by the Institute for Reproductive Health (IRH) at Georgetown University. This natural method relies on noticing the presence or absence of cervical secretions to determine whether or not a woman is fertile each day. She should consider herself fertile today if she notices cervical secretions of any type today or yesterday. To correctly use the method, she should avoid unprotected intercourse on fertile days to prevent pregnancy. If she noticed no cervical secretions of any type today or yesterday, her probability of pregnancy from intercourse today is very low<sup>1</sup>.

An efficacy trial found that the TDM was more than 96% effective with correct use and more than 86% effective with typical use. These effectiveness rates are similar to those of a number of other user-dependent methods<sup>2</sup>.

The TDM has been offered in Africa since mid-2007, as funded under the AWARENESS Project granted to IRH by the United States Agency for International Development (USAID). IRH piloted the TDM in two faith-based organizations (FBOs): Action Familiale Rwandaise (AFR) in Rwanda and Conduite de la Fécondité (CF) in the Democratic Republic of Congo (DRC). IRH trained 18 FBO natural family planning (NFP) providers on the TDM in each of the two countries. These FBOs providers are experienced in using and providing other NFP methods, including the Billings Ovulation Method and the Symptothermal Method. After these providers were trained on the TDM, IRH brought them together in focus groups to assess issues related to training experienced NFP providers on the TDM. The information gathered during these focus-groups is helping IRH address a number of issues that may impact future TDM service delivery in the context of African FBOs.

### **1.2 Justification**

Like some other fertility awareness-based methods of family planning such as the Billings Ovulation Method and the Symptothermal Method, the TDM relies on the detection of cervical secretions. Unlike these methods however, the rules of the TDM do not require distinguishing among different types of cervical secretions. Rather, the presence of secretions of any type is considered the only indicator of fertility. Secretions are considered any substance that the woman perceives as coming from her vagina, except for menstrual bleeding or post-coital semen. Since many FBO providers are experienced in offering the Billings

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<sup>1</sup> Arevalo, M., Jennings, V., & Sinai, I. (2003). Application of simple fertility awareness-based methods of family planning to breastfeeding women. *Fertility and Sterility* Vol. 80, No. 5.

<sup>2</sup> Hatcher R. et al., (2004). Fertility Awareness-based Methods. *Contraceptive Technology* 317-329.

Ovulation Method and the Symptothermal Method, there is a concern that providers will combine aspects of these other methods with the TDM when counseling clients, which may result in confusion and high rates of incorrect use. The purpose of the focus groups was to determine the potential for confusion in the providers' understanding of the TDM and how to offer it.

### **1.3 Study sites**

The TDM was included in the programs of two FBOs in Africa: AFR in Rwanda and CF in DRC.

#### ***Action Familiale, Rwanda***

AFR was founded in 1985 by the Rwanda Catholic Bishops Conference. The mission of AFR is to offer couples fertility awareness-based methods of family planning as well as family life education. The goal of AFR is to integrate NFP services in the educational services of the Catholic Church at the regional level (diocese) as well as the local level (churches, and church-run community health centers). AFR has a long history providing natural methods of family planning in Rwanda. Since emerging in 2004 from a decade-long hiatus caused by the genocide, AFR has regrouped and has become fully operational. AFR operates a central coordinating office as well as regional offices and local health services. AFR offers self-observation methods of family planning such as Billings and symptothermal, as well as the Lactational Amenorrhea Method (LAM)<sup>3</sup>, and the Standard Days Method<sup>®</sup> (SDM)<sup>4</sup>. The TDM is being piloted in the Diocese of Kabgayi and Kigali.

#### ***Conduite de la Fécondité, DRC***

CF is a diocesan institution working in Kinshasa in the field of reproductive health with a specialization in NFP. Since its creation in 1982, CF has been providing education populations on topics related to reproductive health and offering training and in-home follow-up on self-observation methods to couples who desire to space births. In addition, CF offers other methods of family planning such as LAM as well as psycho-social services to HIV positive community members and their families. In 2004, CF expanded its family planning method mix with the integration of the SDM. CF works primarily through couple instructors (currently 75 instructors) who conduct information sessions in communities on all methods of family planning, referring those interested in hormonal methods to health centers while conducting one-on-one counseling for couples interested in natural methods. Instructors based in Kinshasa were trained to offer the TDM.

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<sup>3</sup> AFR teaches a version of LAM which covers the first 9 months of the post-partum period, based on a research study conducted in Rwanda which showed it to be fairly effective.

<sup>4</sup> AFR has offered the SDM since mid-2007.

## **2. RESEARCH METHODOLOGY**

### **2.1 Design**

Focus groups discussions (FGDs) were organized about three months after the providers were trained on the TDM. Seventeen female instructors participated in three FGDs conducted in Rwanda in August 2007, while 12 female instructors and one male instructor participated in two FGDs held in the DRC in September 2007, each group consisting of five to eight providers. At the time, most providers had started using the method themselves and a few had begun offering it to clients. The same facilitator was used for all the FGDs in both Rwanda and the DRC. In addition, a rapporteur was present in each FGD to tape sessions and take notes. IRH developed a FGD guide and trained the facilitator (the training also served as an opportunity to review and make necessary language and sentence structure adjustments). The study was approved by Georgetown University's Institutional Review Board. Consent forms (in French for DRC and in Kinyarwanda for Rwanda) were also developed by IRH, and the facilitator was trained on how to obtain signed consent from all of the participants.

The objectives of these focus groups were to:

1. Determine the potential for confusion for FBO providers who are experienced in Billings.
2. Explore the attitude and opinions of FBO providers regarding the TDM.

The following issues were explored in these focus groups:

- Influence of the Billings Ovulation Method and/or the sympto-thermal method on providers' understanding of the TDM.
- Influence of the Billings Ovulation Method and/or the sympto-thermal method on how providers teach the TDM .
- Attitudes and opinions of providers regarding the TDM
  - Do providers think the TDM is appropriate for their clients?
  - Do providers think the TDM is effective?
  - Do providers think the TDM is easy to teach?
- Do providers have suggestions about how the TDM can be improved?
- Do providers have suggestions about how to make the TDM more accessible?

### **2.2 Data collection and analysis**

Data analysis was conducted by IRH. Tapes of focus groups sessions were transcribed. Notes taken during the focus groups and tape transcripts were reviewed to identify similarities, differences, and relationships among emerging themes and key messages in relation to the objectives and research questions. A report with key findings and recommendations has been shared with the FBO Director in each country.

## **2.3 Training**

In Rwanda, IRH's Country Representative and the Director of AFR trained 18 female instructors working for AFR on the TDM from May 7 to 8, 2007. In the DRC, the Country Representative and the CF Director trained 14 instructors from June 25 to 26, 2007. The training in Rwanda was conducted in Kinyarwanda with all materials similarly translated to correspond with the education level of the AFR instructors. Both trainings were based on the standard training developed by IRH with slight adaptations to the context. In particular, sessions delving into the concept of family life education—including abstinence, discussing sexuality and couple issues—were added. These sessions were requested by the FBOs to better integrate the TDM into their NFP programs. In addition, the trainers led a specific discussion about secretions and the differences between this method and other NFP methods, particularly the Billings method, as all the instructors were experienced Billings providers and IRH wanted to minimize the effect of their previous experience with Billings on the TDM counseling. At the request of the AFR director, participants were asked to use the method themselves for at least one month to increase their understanding and acceptance of the TDM. In the DRC, the director felt that the instructors were prepared to begin offering the method in the community immediately after training. Thus, there was not a waiting period before instructors began offering the method as was the case in Rwanda.

## **2.4 Monitoring and supervision**

IRH regularly contacted the directors of the two FBOs during the study period who, in turn, made supervision visits to the field. Both organizations have supervision structures whereby the national office supervises the Diocesan level, which in turn supervises the parish level. However, because this period focused on assessing the quality of the TDM training and the ability of instructors to use the method rather than on expanding services, further integration into the FBOs' monitoring and supervision systems—i.e. integration into their service statistics and reporting mechanisms—did not occur.

Monitoring was also built into the refresher trainings in the two countries. A one-day refresher training, again led by IRH's Country Representative and the FBO Director in each country, was held approximately one month after the initial training in Rwanda and three months after the initial training in the DRC, to assess how well the instructors were able to use the method, answer questions, and reinforce concepts as necessary. During those sessions, the trainers checked the client cards of the instructors who had been using the method and corrected any inconsistencies, reinforcing proper use. At that point, IRH and AFR instructed the instructors to begin offering the method to interested and eligible clients. In the DRC, a few of the trained instructors had already begun offering the method to their clients shortly after receiving training. At the refresher training, they shared their clients' experiences using the TDM.

## **2.5 Information, education, and communication (IEC) activities**

All of the tools used during the training—including the job aids, the participant notebook and the client card—were adapted from the TDM tools used during the original efficacy trial. In Rwanda, modifications requested by AFR included translation into Kinyarwanda and a change in the symbols used to indicate menstruation, secretions and no secretions. Since the symbols “x” and “o” are used by AFR to teach other fertility awareness-based methods, the AFR director was concerned that this might affect the instructor’s ability to teach the TDM effectively. Orientation meetings were held with church leaders and heads of selected faith-based health centers to increase awareness about the TDM and its availability through the AFR. Once the AFR instructors were instructed to begin offering the TDM in the community, information about the method was integrated into the instructor’s outreach activities within the parish. AFR’s delivery model relies on presentations to large groups to inform parishioners about available services. Interested couples usually approach the instructor and arrange a time for a couple’s consultation. In the DRC, the decision of when to start offering the method to clients was left to CF. In addition to using the method themselves, the instructors unofficially included it in their method mix. As of the date of the refresher training in DRC, three instructors had offered the method to one or two clients each.

## **3. DISCUSSION**

### **3.1 Provider knowledge and attitudes, program implications**

The instructors participating in the focus groups in Rwanda and in the DRC demonstrated knowledge of the TDM and a theoretical ability to offer it, meaning that they were able to cite the eligibility criteria and provide adequate counseling in a role-play situation. However, many of the participants (approximately half in Rwanda and one-third in the DRC) had not yet had the opportunity to offer the method to clients. The instructors who had provided the TDM to clients had not yet conducted follow-up visits with clients and were unable to report whether the users were using the method correctly.

In the FGD, participants were able to elaborate on the key themes of a TDM counseling session, including the definition of secretions, when to check for secretions, definition of the menstrual cycle, when to abstain, and how to fill in the client card. However, based on role plays of counseling, the facilitator identified a need to reinforce use of provider job aids among the instructors. The participants emphasized the importance of clearly explaining to clients why the method is called the TDM, because clients could assume that the name of the method implies that secretions will only be present for two days or that abstinence is only required for two days. Having incorrect information about the fertile period could lead to unprotected sex during a fertile day. Participants also said that they anticipated that clients would say that they were familiar with

cervical secretions, in the Billings sense of the word (the difference between *glaire cervicale* and *sécrétions* in French), and that they as instructors would need to emphasize that with this method it is the presence or absence that is important and not the quality of the secretions. Interestingly, in discussion and in simulations of a counseling session, participants routinely neglected to consider potential clients' risk of acquiring sexually transmitted infections, which would affect perceptions of cervical secretions. This is likely due to their focus on family life and abstinence; nevertheless, it will be important to emphasize in refresher trainings.

Different opinions of the method were expressed during the FGDs. Instructors who used the method (about half) found the method to be simple. Some believed that the TDM is easier than Billings for clients because women are more likely to notice presence or absence of secretions rather than be able to distinguish qualities of secretions. They also felt that the accompanying materials, such as the client card, helped simplify the method. However, others liked it less than Billings because of their perception that it requires more days of abstinence and because of certain eligibility criteria. In particular, providers disliked the fact that post-partum women must wait at least three menstrual cycles before beginning to use the TDM. This criterion is based on research showing that the high average number of days with false-positive secretions that post-partum women experience in the first three cycles would lead to many days of abstinence and might make it unacceptable to women<sup>5</sup>. They also had questions about how to judge eligibility if women notice secretions one or two days before their period, or all the time (i.e. no dry days). Others felt that it was too soon for them to give their opinion, since they had not had experience offering it. Finally, some participants—particularly those from CF—wanted to combine the TDM with other NFP methods—either Billings or cervical observation. This appears to be out of a tendency to be as certain as possible in identifying fertile days.

Thus, it appears that these instructors, who are experienced Billings providers, clearly understand the difference between Billings (and other NFP methods) and the TDM and find it to be another appropriate choice for couples. However, in their own words, they do not yet feel confident about their counseling skills since they have not had many opportunities to offer it to couples. Furthermore, they did not report any potential problems for integrating the TDM into their current programs.

### **3.2 Lessons learned**

It must be noted that because many of the instructors did not have the opportunity to offer the method to clients, their ability to respond to certain questions and provide feedback was somewhat limited. In addition, most of the instructors were volunteers, who usually provide methods once a week. Given

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<sup>5</sup> Arevalo, M., Jennings, V., & Sinai, I. (2003). Application of simple fertility awareness-based methods of family planning to breastfeeding women. *Fertility and Sterility* Vol. 80, No. 5.

that these FBOs have a multi-step approach to recruitment (first large-group sensitization, then one-on-one sensitization, then one-on-one counseling) which can be time consuming, there was insufficient time between the initial training and conclusion of the study to allow the instructors to offer the method. Both organizations' reliance on part-time volunteers to deliver family planning methods to the community needs to be taken into account when setting patient flow targets for future studies or programs.

Involving parish and Diocesan leaders and local health administrators in the planning of activities secured their support for the study and commitment for future plans to integrate the TDM into existing family planning services.

### **3.3 Recommendations**

The following are recommendations from participants:

- Additional refresher trainings, since they have not yet had the opportunity to offer the method to many clients, as well as ongoing supervision;
- Broad launch of the method to increase awareness among communities of its availability;
- A specific follow-up form or register for TDM clients;
- Adaptation of certain images and messages in the client materials (should be explored and tested);
- Revision of the client card to allow for space to write the date next to the days of the week, and include a symbol to indicate when couples had sex (as done for other methods); and
- Expansion of the pilot intervention to an additional Diocese in each country.

In addition, IRH recommends that another round of FGDs be conducted once instructors have offered the method to a larger number of clients so that richer discussions are possible. As part of refresher training, it must be made clear that the TDM should not be offered in conjunction with another NFP method.

Furthermore, the fact that both groups indicated the probability of confusion with the name, TDM, it may be advisable to begin thinking of alternative and context-appropriate names.