

Pia: Greetings and welcome to today's webinar on Fertility Awareness Methods. My name is Pia Kochhar and I am the Knowledge Management Coordinator for the Advancing Partners and Communities Project. Before we begin today's presentations, I'd like to quickly review the Adobe Connect Environment and set a few norms for today's webinar.

Today's webinar has three presentations followed by a discussion period, during which our speakers will address your questions. Within the webinar environment, please make use of the Q&A box, on the bottom right-side of your screen to share your thoughts, note your questions, or ask for help with sound during the presentation. Questions you ask are only visible to you, our presenters, and technical support. If you are experiencing difficulties our technical support will respond to your question privately. We will collect your questions for our speakers and will save them for the discussion period.

It is great that we are able to connect people from so many places today, but your experience may vary based on your internet connection and computer equipment. I will briefly go over a few troubleshooting steps if you have technology challenges today. A few troubleshooting tips. If you lose connectivity or cannot hear, close the webinar, re-enter the meeting room in a browser other than Google Chrome by clicking on the webinar link provided. Use the Q&A box to ask APC Tech for assistance. If the troubleshooting steps are not successful, please rest assured the webinar is being recorded and you will receive an email with a link to the recording following today's event.

Questions that don't get answered during the Q&A sessions will be compiled after the webinar, shared with presenters, and responses from presenters will be shared with participants. To get us started I will now turn it over to our Moderator, Clifton Kenon.

Clifton: Good day everyone from whatever part of the world you are joining from. Thank you for being here once again. My name is Clifton Kenon and I am with the Population and Reproductive Health Office at the United States Agency for International Development. This webinar today is sponsored jointly by the APC Project, IBP and FP2020. This is a part of a Methods Series and today we will be focusing on Fertility Awareness Methods. Each one of these series will focus on one single method. Our target audiences are first and foremost, those who are interested in that specific method, including Ministries of Health, Policy Makers,

Program Managers, Researchers, Donor, students etc.

What we will go over in these webinars, specifically the one today will include:

What the methods are; how to use them; their efficacy; how they work; and then the implications on where they can be utilized. We will use country case studies and we will explore a variety of service delivery methods. With that being said, it is my pleasure to introduce our first panelist and speaker of the morning, Dr. Dominick Shattuck from the Institute for Reproductive Health at Georgetown University, where he is Senior Scientist.

Dominick: All right, thanks Clifton, I hope everyone can hear me okay. Yes, it's my pleasure to be here today as we wait for the slide to start loading. But, I'll kind of start off by saying, IRH has a long history of doing research and implementing Fertility Awareness Methods in the field globally and we're really happy to share this experience with you today.

Just to kind of start off, okay, here we go. Natural family planning methods, such as the **billing** ovulation method and the **symptothermal** method, have been available for many years. And in the last decade, simple effective fertility awareness methods, such as the standard days method, the two days method and Lactational and Amenorrhea method or LAM were developed and tested by Georgetown University's Institute Group in **[inaudible]**.

Sorry, I was trying to advance my slide, one moment.

Pia: You can use the two arrows on the bottom left corner.

Dominick: Oh, thank you. My – okay.

So, during your recycle, a woman has a number of fertile days, and those fertile days are determined by the timing of her ovulation and the lifespan of sperm. The fertile window can be tracked by answering one of two questions. First, what day of the cycle am I on today? Which is determined or which is done by tracking days of the cycle or it can be identified by answering the question, what do I feel or observe today in my body? Where women observe changes or symptoms indicate fertility.

The standard days method is a simple fertility awareness based method of family planning, based on a woman's menstrual cycle.

Appropriate for women who usually have menstrual cycles between 26 and 32 days long. The method identifies days 8 through 19 as the fertile days. In addition to providing significant protections from unwanted pregnancies, modern methods of family planning show certain characteristics including that they first are based on a sound understanding of reproductive biology. Second, follow a precise protocol for correct use, and third have been tested and in an appropriately designed study to assess efficacy under various conditions.

SDM meets these criteria and as such is regarded as a modern method by international organizations and ministries of health around the world. The effectiveness of SDM is **similar to user dependent methods**. Initially developed in 2001, the method was tested in 500 women in three countries, Bolivia, Peru and the Philippines, and has now been introduced in over 30 countries worldwide including the United States.

With a combination of probabilities, the probability of pregnancy on different cycle days related to ovulation and the probability of the timing of ovulation it was possible to identify the days when pregnancy is very likely, and the days when it is most unlikely. In menstrual cycles between 26 and 32 days long, which account for more than 80 percent of all cycles, the days pregnancy is very likely, are days 8 through 19. On all the other days pregnancy is very unlikely. Cycle **beads** represent the menstrual cycle, the red bead represents the first day of menstruation, which also is the first day of the cycle. The brown beads represent when pregnancy is very unlikely, the white beads represent fertile days.

A movable rubber ring marks each day of the woman's cycle. The cylinder with an arrow indicates the direction in which the ring should be moved. Because this method works best for women with cycles between 26 and 32 days long, there's a darker brown bead to let you know if you have a shorter cycle, if you get your period before reaching the dark brown bead, your cycle is shorter than 25 days. And this may not be as effective for you; this method may not be as effective for you. And there are also 32 beads here, so if you don't get your period by the day after the ring is put on the last bead, your cycle maybe longer than 32 days, and again the method may not be the right method for the woman.

The medical recommendation is that if a woman has a cycle outside of this range more than once in a given year, that you use a different family planning method. We've seen that cervical

secretions are a reliable indicator of fertility. This method is based on the presence of secretions to identify fertile days. The users of two-day method, check themselves every day to see if they have cervical secretions or not. They need to know only if they have secretions or not. They do not need to distinguish characteristics of secretions, such as the amount or the color or consistency, or slipperiness or **sketchability**.

If a woman has not had any secretions of any type today or yesterday, she considers herself not fertile. Therefore, the name two day if she's had two consecutive days without secretions her probably of becoming pregnant today is very low. The two-day method works by using cervical secretions as an indicator of fertility. The woman checks daily for presence or absence of secretions of any type. If the woman has noticed secretion today or yesterday she considers herself fertile today, and abstains from sex today, if she wants to avoid pregnancy. Thus, the name of the method, the user takes two days, today and yesterday in to account in deciding whether she can have sex today.

To use the two-day method correctly the user follows three steps. First, she checks whether secretions are present, twice a day, in the afternoon and in the evening. Second, she records secretions at the end of the day in a marking calendar, and third, she determines if she is fertile or not by asking herself, did I have secretions yesterday or today?

[Crosstalk]

Clifton: Hi, Dr. Shattuck, this is Clifton, I wanna just remind you to advance your slides, I've been advancing them for you, but I wanna make sure I'm on the same one with you.

Dominick: You are, and I'm sorry about that, I thought I was. Yeah, so the Lactational and Amenorrhea method also known as LAM, is a family planning method based on the hormonal suppression of ovulation caused by breast feeding. But, this method is of strategic important because LAM serves as a gateway to other modern methods of family planning. So, I wanna keep this in mind throughout this session as we will discuss it in much more detail later.

LAM prevents pregnancy by interfering with the release of hormones that allow ovulation. Secondly, stimulates production of a hormone that tells the brain not to release the hormones

necessary for ovulation. Regular and frequent nipple stimulation is necessary to ensure a continuous stimulation of the brain. The three criteria of LAM required are that – this would have the images in here, but apparently, they're not coming up. That a woman her period has not returned since she's had the baby; that she is exclusively breast feeding; and that her baby is less than six months old.

So, there is several common misconceptions about LAM, in fact there actually is significant demands of these methods in the field, and **FAM** users are often first-time family planning users or women who've had challenges using other hormonal methods. So, now I'm gonna go in to a little bit of evidence in the research that has been, or example of the research that has been put forth to support the use of FAM as a family planning method. As stated earlier, **FEM** as recognized as a modern effect family planning method, and there's a robust body of evidence for this method in the literature in the **[inaudible]** **[00:13:06]** reviewed literature.

Also, the inclusion of SDM helps to promote a family planning method mix that has a robust variety for many different types of users. The typical use failure rates of FAM are comparable to other user directed methods. So, now I'll go in to a couple of examples of the acceptability of FAM and how it brings new users in to the method mix. The second reason that **[inaudible]** should integrate SDM is because it doesn't address women's concerns about family planning and it does address women's concerns about family planning such as side effects and fills a critical gap.

In studies conducted in several countries we find the overwhelming reason why women choose SDM, is that it doesn't affect their health and it has no side effects. And it's evidenced that SDM attracts first time users to family planning. In all three countries where IRH conducted impact studies, the great majority of SDM users were women who had not used modern methods before. SDM users are additive to the national CPR and bring in people who are not interested in using other types of modern family planning methods. So, SDM, as part of a robust method mix and part of an informed choice procedure, places emphasis on couples and raises men's participation in fertility.

SDM has been integrated in to under served and low literacy settings, and it also has the history and materials to ensure quality and quality of service delivery when integrated. SDM has been implemented across the range of settings in using a variety of

models from community health workers to using social marketing and recently in Uganda using some group learning methodologies. Recently these [inaudible] [00:15:33] fertility awareness based methods have been converted to digital platforms in the form of apps, and they are available across the globe. IRH is currently working on a prospective efficacy study of one digital method DOT, that will be completed in the Fall of 2019.

Thanks for listening today, I'm sure we'll share these shares and be available to answer any questions and materials as needed. Okay back to you Clifton.

Clifton: Thank you very much Dr. Shattuck. Just a couple of reminders, we did experience some technical difficulties, but we have concluded that the best way to move forward is for everyone to advance their own slides and the speaker will notate when they are moving from one slide to the next. If you look in your presentation window at the bottom, there are two arrows down the screen from the sync button, and you can use those to advance your slides. It is my pleasure now to introduce our next speaker Dr. Chelsea Polis from the Guttmacher Institute, who will be speaking about research on fertility awareness based methods. Dr. Polis, we turn it over to you.

[00:16:52 – 00:17:20]

Pia: Hey Chelsea, we can't hear you.

[00:17:21 – 00:17:48]

Chelsea: Hi, are you able to hear me now?

Pia: Yes, we can hear you now.

Chelsea: Great, sorry about that everybody. Greetings, to everybody, I'm really happy to see so many people on the webinar today, and I'd like to really thank the organizers for inviting me to participate in the webinar. I'll be discussing recent and upcoming research on fertility awareness based methods, or as I'll call them throughout the presentation FABMs. Given that we have some technical difficulties on the slides, I'm just gonna do a little test here. I've just advanced my slide, could somebody let me know if that does show up for others, or if I should indicate when each person should advance their own slide individually.

It did change. Wonderful.

Pia: It did change, great.

Chelsea: Okay, if it doesn't change at any point through my presentation, please do jump in and let me know so that I can indicate for the participants to advance their own slides.

So, today, I'm gonna briefly describe a research study that I've been involved with for a couple of years now, working with a team to do a comprehensive systematic review of prospective clinical studies, assessing the effectiveness of FABMs for pregnancy prevention. Next, I'll provide a few examples of other recent and ongoing FABM research, then I'll mention a couple of resources, that contain FABM and relevant information and finally, I'll wrap up with a few concluding thoughts on FABM research. And I'd just like to note that the views in this presentation are mine, and may not reflect the views of my employer or funders.

And I'd also like to acknowledge several people who are listed on this slide who provided very helpful discussion and input on this topic.

So, why should we study FABM effectiveness? Providing clear information on the risk and benefits of various contraceptive options including information on contraceptive effectiveness, helps to support informed choice, so that people can choose the method that works best for them in the context of their own lives. Also, as new ways of FABMs emerge, such as those that are using smartphone apps, effectiveness rates can change. So, this is also an important issue to study over time. However, studying FABM effectiveness is complicated.

For one thing there are a range of different FABMs, and Dominick just mentioned several in his presentation that are commonly included in international programming. And a few other types do also exist, as I'll show briefly on the next slide. Each of these individual FABMs may have a unique effectiveness profile. So, studying FABM effectiveness requires studying several different types of methods. Also, different data collection approaches to studying effectiveness have unique advantages and disadvantages, which I'll discuss in a little bit.

And finally, among studies estimate FABM effectiveness, methodological quality varies widely. So, for example, many studies have used in appropriate estimate approaches that can

provide misleading information. So, providing clear information to people about FABM effectiveness require grappling with all of this and more. As I mentioned, there are several categories of FABMS, each of which use different biomarkers of fertility to identify the beginning and end of a fertile window within each menstrual cycle for a woman.

So, within each category our specific FABM methods that each use slightly different rules to interpret those biomarkers. So, briefly, calendar based methods, which are show here in blue, involve counting which day of the menstrual cycle a woman is on. Cervical mucus based methods in pink, involve observing the presence and quality of cervical mucus. Temperature based methods, shown in yellow, require taking daily basal body temperature, and interpreting temperature shifts over time. Sometimes in conjunction with other biomarkers.

Sympto-thermal methods, in purple, require tracking multiple indicators, often cervical mucus along with basal body temperature. And finally, urinary hormone based methods, in green, use a monitor to measure hormone levels in urine, sometimes combined with also tracking observations of cervical mucus. In the United States and internationally rhythm is the most commonly reported FABM, and unfortunately rhythm is probably among the least effective FABMs.

Currently, the most commonly cited first year, typically use pregnancy rate, sometimes called a failure rate, among women reporting use of any FABM is 24 percent. That estimate is based on data from 1995 and 2002 collected at a nationally representative survey that's regularly done in the United States, called the National Survey of Family Growth or the NSFG. Effectiveness estimates based on large surveys, like NSFG, have the advantage of permitting estimation among a wide range of users with different demographic characteristics. And that can help to enhance generalizability or the ability to make statements about a broad population.

However, such estimates rely on part upon womens' accurate recall and reporting of key information. Things like what contraceptive she was using three years ago, what pregnancy experiences she's has over the last few years, things like that. Also since the number of FABM users in the United States is relatively low, researchers face certain analytic constraints, which often necessitates that they lump all FABM methods together in order to

have enough statistical power to generate effectiveness estimates. Even though each FABM might have a different effectiveness profile.

So, if the goal is to understand effectiveness of individual FABMS, this lumping, as is done with the 24 percent estimate, is not ideal. But what the 24 percent estimate does tell us, is the typical use failure rate of most women in the United States who report use of any FABM, which we know is largely comprised of women using rhythm, or reporting rhythm. So, data for prospective studies, like clinical trials maybe less generalizable, but they do allow for prospective collection of important information on contraceptive use and pregnancies. And can be used to study the effectiveness of the individual FABMs, without needing to lump methods together.

Also, unlike data from surveys, data from clinical trials allow for calculation of perfect use pregnancy rates, which tell you how effective the method is when it's used perfectly every time. For people who are interested in more detail on the nuances of some of these advantages and disadvantages of surveys and clinical studies for estimating contraceptive effectiveness, I encourage you to check out this blog on this issue which is linked here.

So, given this background, a team of researchers that I've been working with decided that a systematic review of FABM effectiveness and prospective studies was needed. And we're very grateful to USAID for supporting this work, and to Dr. [Rachel Peragallo Urrutia](#) who led this project. We conducted a very comprehensive systematic literature search of multiple databases to identify all available peer reviewed prospective clinical studies, estimating the effectiveness of each specific FABM. And we also developed a 13 items quality assessment framework, in order to rigorously and systematically evaluate the methodological quality of each included study.

So, we're very hopeful that this framework will also be a methodological contribution to the field, in that it can be considered in designing future high-quality studies on FABM effectiveness. So, after collecting all the studies developing this framework, we ran each study through the quality assessment framework, and we classified studies according to quality, and then we summarized the best available evidence on FABM effectiveness. I wanted to mention one really interesting feature of this project, is that we had a very multi-disciplinary team, including clinicians, epidemiologists, stenographers, and FABM

teachers.

And we fostered an environment of what we call, oppositional collaboration, in that our team members held a wide range of viewpoints and a diversity of moral beliefs, which we will helped us to minimize biases and to enable a very sharp focus on the data and on the science, which is critical. And even on a topic – and permitted to us to really be able to do this on a topic that can be somewhat complicated and even sometimes controversial. So, we've now completed all of the work on the systematic review and we just recently submitted the manuscript for consideration in a [Paraview](#) Journal.

So, although, since those methods are currently under review, I can't share of the results of the review with you today, but I encourage you to stay tuned, as we're hopeful that we might have something published within the next year. So, on this slide are shown a few examples of ongoing or recent FABM related research. This is not an exhaustive list, although I did ask around to several folks who work on FABM issues, and the general sense is that there's not an enormous amount of FABM studies that are currently under way.

There are two recent effectiveness studies to mention, for this internationally focused audience on this webinar, and both of these involve mobile apps. The natural cycles effectiveness study is recently completed, but it's interesting to mention here, because it's the first mobile application certified in Europe for use as contraception. The app requires users to track basal body temperature and dates of menstruation, and optionally they can also track [luteinizing](#) hormone test results. So, a study of over 23,000 users reported a perfect use failure rate of one percent, and a typical use failure rate ranging between 6.9 and 9.3, depending on how the analysis was done.

The [dot](#) study is another one to mention, and that's a study that Dominick mentioned, being conducted by the Institute of Reproductive Health at Georgetown. Dot is an app developed by Cycle Technologies, women enter their period start dates and the app uses a proprietary algorithm to flag days of high or low fertility. As Dominick mentioned, a prospective study is currently under way to estimate perfect and typical use effectiveness among women aged 18 to 39. Over 700 women have been involved so far, and results are expected in winter of 2018.

A few examples of other recent or ongoing topics being studied include a paper coming out soon from IRH, assessing whether promotion of the cycle **based** app brings new users to family planning, trying to understand the experience of cycle based app users in Kenya, and trying to determine how user experience varies by distribution channel. So, this paper will be coming out soon in international perspectives on sexual and reproductive health. A few papers have popped up recently in the literature **[inaudible]** **[00:28:27]** whether different indicators, such as using wearables to track wrist skin temperature may or may not be reliable by **[inaudible]** FABMs.

These kinds of things are at a much earlier stage of development compared with other FABMs. And finally, a small analysis that some colleagues and I are working on. Considers whether use of multiple contraceptive methods, such as women who use an FABM in conjunction with condoms impacts the estimation of FABM prevalence in the United States. So, these are just a few examples, and if there are other major FABM research efforts going on that people are aware of, I'd love to learn more.

I also wanted to mention a few evidenced based resources on FABMs that might be useful and relevant for providers and programmers. One is the book, *Contraceptive Technology*, and this has really been a leading family planning resource for over 20 years. The picture shown here, the little green book on the left of the slide is of the 20th edition of this book, and a new 21st edition is expected to be published in mid-2018. This is a large book, over 900 pages and it includes detailed chapters on all contraceptive methods, as well as a range of other subjects. And this includes a chapter co-authored by Victoria Jennings and myself on FABMs.

So, this resource will be available for purchase next year. The other two resources I will mention are both available freely online. The first is the WHO medical eligibility criteria for contraceptive use, sometimes called the **MEC**, and this is currently in its 5th edition. This document provides guidance on the safety of various contraceptive methods in the context of specific health conditions and characteristics. For FABMs the MEC notes that there are no medical conditions that become worse because of the use of FABMs, and it describes various conditions which make using FABMs more complex.

Things like, breast feeding, being post-**partum** etc. And for each condition it suggest whether users can use that method within that

particular characteristic or whether they should delay using that method or proceed with caution and special counselling. And the MEC also offers guidance for using lactational amenorrhea method, including considerations for those women who may be living with HIV.

Finally, the family planning handbook is a collaboration between **Joss Hopkins** WHO, USAID, and many other organizations. And it offers clinic based health care professionals in developing countries, guidance on providing contraceptive methods. So, this book does contain a chapter on FABMS and that includes an overview on how to provide for and counsel for these methods. How to assist continuing users and a range of other helpful Q&As.

So, it's [inaudible] [00:31:17] beginning of this talk, providing clear information about contraceptive options, including their risks and benefits and their effectiveness is a key part of informed choice, and of a client centered approach to high quality family planning. To provide clear information to clients, we need high quality evidence on which to base those messages. So, support for science and research is critical. A range of people maybe interested in FABMs, and certain populations might particularly benefit from information on modern FABMs.

For example, rhythm is the most widely reported FABM in the United States and in many countries around the world, but rhythm is likely among the least effective types of FABMs. So, these users might be a particularly important population to reach. Other examples include people classified as having unmet need due to concerns about side effects, or people who have religious or other objections to other family planning options. There is substantial misunderstanding around FABMs, and there's been a lot of recent debate in the literature about these methods.

And, as I hope our oppositional collaboration approach with the systematic review shows, we should channel healthy debate on FABMs towards better science and constructively harness the value of diverse perspectives. While several research studies are ongoing such as the systematic review, some effectiveness studies and a few other projects, FABM research does remain limited and offers fertile ground for study. One particularly interesting aspect of these methods is the potential to incorporate technology. So, not only things like smartphone applications, but also devices that automatically check biomarkers of fertility.

These kinds of examples are kind of exciting and forward-looking ideas, but this work will also continue to raise very important questions. Things like, how should regulatory bodies think about regulating these methods and how research studies should be most appropriate designed to assess these methods?

And finally, as noted, there are several evidenced based resources that do contain some FABM information, and this continues to grow over time. So, I'd like to thank all of you very much for your attention today. I'm looking forward to the discussion, and if you have any questions you can feel free to reach out to me at this email address shown. Thank you and I'll turn the presentation back over to Clifton.

Clifton: Thank you very much Dr. Polis, for an outstanding presentation along with Dr. Shattuck. I do want to pose a reminder that if you have questions as we're going through the presentation, please begin to type them in to the Q&A box, and we will attend to these at the end of the presentation, hopefully starting the facilitation of this healthy debate that Dr. Polis has talked about. We're going to turn it over to our final presenter for this morning, or afternoon, or evening, depending on where you're from. Adrienne Allison of World Vision will now be talking about some on the ground experiences. Adrienne we're happy to turn the time over to you at this time.

Adrienne: Thank you Clifton. Greetings to everyone, and thank you to the organizers for this opportunity to highlight some of World Vision's experience with Fertility Awareness Methods and Male Engagement. The presentation builds on the excellent presentations by Dominick Shattuck and Chelsea Polis, by just going to apply their lessons to the field. We'll briefly review partnering with Ministries of Health, World Vision's approach to family planning, which is health planning and spacing of pregnancy. The importance of male engagement, the standard days method, and examples from Kenya, Senegal and India.

World Vision builds the capacities of Ministries of Health to provide family planning, counselling, and services to meet client needs. Concurrently we train community health workers to counsel on short and longer-term methods, to distribute condoms, and oral contraceptive pills, if approved by the Ministry of Health, and to refer clients to Ministry of Health facilities for long acting methods. All providers are supported through training on improved methods of data collection, because that is such a challenge.

Occasionally, World Visions also uses private funds to supplement facility equipment.

World Vision focuses on improving maternal and child health through healthy timing and spacing of pregnancies, rather than focusing on the economic or demographic dividends that maybe realized at a national level. Healthy timing and spacing of pregnancies or HTSP, helps women and men delay, space, and limit pregnancies for healthiest outcomes. HTSP works within the context of free and informed contraceptive choice, considering fertility **intentions** and desired family size. All World Vision's programs include four key messages that are on the screen, but they're a little vague so I will read them to you.

First, delay the first pregnancy until the girl is at least 18. Wait until a child is at least two before trying for another pregnancy. Wait at least six months after a miscarriage or abortion before trying for another pregnancy. And, limit pregnancies to the mother's healthiest years for pregnancy, ages 18 to 34. Provider and parents remember these messages simply as, avoid pregnancies when the person is too young or too old, and avoid pregnancies that are too close, and too soon, too early.

Now we turn to men, because World Vision works in rural areas, which are less developed and we have found men are essential in traditional societies, because they are the gatekeepers who control access to resources like time and money. They often are the decision makers about timing and spacing their wives' pregnancies. However, we are finding that men feel ignored and uninformed about contraception and HTSP. Men do want to know more. An example, in West **[inaudible]** **[00:38:24]** Kenya, the Ministry of Health organized a weekly one-hour call in show on HTSP, led by the Ministry of Health staff and local faith leaders.

Now, 30,000 people in West **[inaudible]** listen to this broadcast every week. Then they began to complain that they didn't have enough air time for their own questions, so the project then introduced a second one-hour call in show from another station, this time led by local male HTSP champions focusing on questions from male listeners. I'm gonna go back, hang on. Initially men were uncomfortable discussing family planning openly. Upon hearing their Muslim or Christian faith leaders talk about HTSP in radio broadcasts weekly sermons, their hesitancy began to fade away.

When faith leaders understand how their respective scripture support abundant life and two full years of breast feeding, they encourage congregations to reconsider traditional beliefs about the value of having many children, and asked them to begin to plan their pregnancies for healthiest outcomes for mothers and their children. I've two examples here, in East **[inaudible]** **[00:40:03]** county where 98 percent of the population is Muslim; World Vision trained almost twice as many male as female community health volunteers who have made remarkable inroads with **Iman, Sheikh** and community elders.

In this project, Iman began to teach male youth in **[inaudible]** about Koranic teachings that support improved maternal health and responsible parenthood. Sheikhs led community conversations to encourage men to actively participate in their family's healthcare. And **health posts** established small men only areas, where men can discuss HTSP and contraception with other men while waiting for their wives.

And a second example, from West **[inaudible]**, men now go to the health facility before their wives to assure the health facility that they approve of their wife's use of contraception when the wife comes the following day with her infant for immunization and contraceptive services and counselling. It's quite curious that the men prefer to come alone to give their assent to the provider, rather than entrusting the woman to do that.

First a word on Fertility Awareness Methods. We have observed that in societies with no tradition of contraceptive use the initial steps succeed when focused on culturally compatible fertility methods, including lactational amenorrhea and the standard days method. These methods are more acceptable as they have no side effects and do not include hormones or medical procedures. LAM based on the natural **accept** of breast feeding on fertility is practiced in most societies, but may be practiced in correctly because of the belief that one cannot ovulate while breast feeding.

The chart shows that in **Gargantua**, community health workers and facility staff had succeeded in accurately recording LAM use. The chart also shows the importance of the standard days method and cycle **beads** as a method of contraception. Cycle beads especially appeal to men as they unlock the "Mystery of the monthly menstrual cycle". They know when they need to use condoms to protect their wives from conception or alternatively the days when conception is most likely. As you see, among all

contracepting women the standard days method is second only to injectables in use. Among all men who use contraception approximately 40 percent preferred the standard days method to condom use.

Next slide. The focus in Kenya on health appeals to Christian pastors and predominantly Christian **Sia** County. After learning about the health benefits of HTSP and how to use cycle beads, pastors encouraged couples to plan their pregnancies. They referred women and their congregations to local health facilities for counselling and contraceptives. Here the data show of the 6,000 women referred by pastors to facilities for contraception 63 actually went and decided to begin to use contraception, 63 percent.

These are wonderful slides because they show men learning how to use cycle beads, and you can see that they are absolutely thrilled with this opportunity. Both the Muslims on the left and the Christians on the right are learning to use cycle beads and understand and appreciating the fact that they now understand more about best times for conceiving and for contraception. In Senegal, a midwife from a health post and a community health worker demonstrate how to use oral contraceptive pills and cycle beads.

Partnerships with Ministries of Health providers together with trained male and female community health workers increased the contraception prevalent rate from 9.5 percent to 17 percent in two years at one health post at the **Lula** health post. This was at a time when the national contraceptive prevalence was just 10 percent. Now, we're going to **Uttar Pradesh**, India.

In India, the program combined LAM and standard based method as natural methods and the pie chart shows the major contribution that natural methods have made to total contraceptive use. Natural methods are the green slice. 40 percent of contraceptives use condoms the blue slice, closely followed by 35 percent who use natural methods. LAM was traditionally practice, although not always correctly. The standard days measure uptake increased when World Vision trained one male for every four female community health workers in Uttar Pradesh. When male health workers discussed standard days method with men uptake increased and became much more popular.

We wanna say thank you to everyone for all their support and for

the World Vision communities where we work. We are grateful to all supporters, thank you. We'll now turn the presentation over to our moderator.

Clifton: Thank you very much Adrienne, and thank you to our other presenters as well. We are gonna transition now to the Q&A period and hopefully facilitate some good discussion. There's a lot of information that has went forth and we will be providing the slides and a video link to this post the webinar. So, we will transition now to our Q&A, and I will be fielding the questions and giving them over to the presenters who I think they're most applicable, certainly recognizing that others could answer as well.

And we're gonna start with a question from [Emeline Smith](#), and this question will be for Dr. Polis. Her question is about the 24 percent that you speak of at the beginning of your presentation, could you expand on that some more, as her question is it's very misleading.

Chelsea: Hi, can you hear me? Hello, are you able to hear me?

Clifton: Yes, we can, proceed.

Chelsea: Okay, great, thank you Clifton. So, it's a little challenging to respond to this comment, because it simply says that the 24 percent is very misleading without additional commentary on what that individual is referring to. So, I'm gonna take a guess here and I'd be happy to follow up with that person or anybody else who is interested in this specific issue.

There has been, I think, quite recently quite a bit of conversation around this 24 percent estimate, including in part because of the petition that was put out by a couple of groups, claiming that the CDC is kind of deliberately misleading people by using this 24 percent typical use estimate for FABMs. As I described in my presentation, I think, it's very important to understand that what this 24 percent estimate accurately reflects is the typical use failure rate of most women in the United States who report use of any FABM, and we know that in the United States over 80 percent of women who report of any use of FABM are reporting use of the rhythm method.

So, I think, it's very important to understand what the meaning of that estimate is, and secondly, I think it's very important to understand that there are analytical constraints that people using

the NSFG data are up against in providing effectiveness estimates for FABMs. And that's specifically because women reporting use of FABMs in the United States is quite low overall. And when you have very few people using a given method you have limited statistical power to be able to produce an estimate for effectiveness of that method.

So, since there are so few users of various FABM methods in the United States, rather than simply not provide an estimate for these methods, analysts have lumped together FABMs to provide an overall estimate for effectiveness for these methods all together. And in several resources where possible, perfect use effectiveness for individual FABMs are provided. So, I would strongly disagree with the sentiment that the 24 percent is misleading, and instead I would encourage people to think about the 24 percent as answering a very specific question. Which is what is the typical use failure rate for the average woman in the United States reporting use of any FABM.

The data on which these estimates are based are collected in the national survey of family group, a very careful collection of data that's been ongoing for many years, and is a very important source of information for all kinds of contraceptive use in the United States. And the analyses on which those estimates are based are also very carefully conducted. This is a very complicated issue, it gets in to a lot of wonky science stuff, and if people are really interested in understanding some of the nuances of this issue, I encourage you to read the blog that I linked in my slide. And I think we will be sharing the link to that blog in some of the follow up materials.

So, I hope that helps to explain a bit more, and again I'm happy to reach out and have conversation with individuals' folks about this if helpful. Thanks.

Pia: Hi Clifton, we can't hear you.

Clifton: Can you hear me now?

Pia: Yes, we can hear you now.

Chelsea: Yes.

Clifton: Okay, perfect. So, our next question is going to be for Adrienne from world Vision, can you talk about the research and the

information that substantiates the science to support the two-year spacing as being ideal? Adrienne, did you hear the question.

Adrienne: I'm sorry, I forgot to unmute. The most compelling information we have that really persuaded World Vision that timing and spacing is important, is the research done by [Shay Rucksteen](#) and Winters, in papers written in 2008 and 2014, that shows an effect of spacing and maternal mortality, child mortality, and also **[inaudible]** **[00:43:28]**. So, those papers are wonderful, thank you.

Clifton: Adrienne, in follow up to that we have an additional question around the six-month post abortion miscarriage. Could you put us to some of the scientific evidence and resources around that also?

Adrienne: Yes, good question. For this, I think, we turn to IRH, because they are expert in this area. I do know that sometimes five months is preferred, but six months is easier for people to remember because it's just half a year. But, please go to IRH website for their data, because it is very good, thank you.

Dominick: Yeah, my colleague, [Lauren Bananck](#) is not with us today, but she is the expert on this in our office. I think it's also around the six-month period where people start to introduce whole foods and solid foods to their babies, which then modifies their eating habits and will change up the frequency in which a woman is breast feeding, and therefore they won't get the same stimulation and they can return to ovulation. And so, I think that is one of the factors contributing to why six months. But, if someone emails to me after this, I'm happy to link them to Lauren who I'm sure can link them to a number of resources and evidence for why that number is determined.

Clifton: So, just as a clarification, I wanna make sure that we are understanding the question. That's great information on LAM, the original question has to do with encouraging woman and families to postpone trying to get pregnant for six months after a miscarriage or abortion. And we attached that on to the question about the two years, Adrienne. Would those resources be the same or do you have additional resources for the six months after a miscarriage or abortion before trying to get pregnant again?

Adrienne: Yes, I think that IRH is one of the best resources for that kind of information. I think, people understand that, because when they look at their own families, they say people who had a miscarriage and then tried to get pregnant immediately again, have another

miscarriage. So, that breathing time for the mother to recover is very important and do ask Lauren for the data, thank you.

Clifton: Okay, the next question we're going to open this up for all the panel and presenters. Does anyone have experience using Fertility Awareness Base Methods in the context of emergency settings or even post conflict setting?

Adrienne: This is Adrienne from World Vision. I know that we are considering this reproductive health in emergency settings, but we are focused mostly on emergency contraceptive pills because they're immediate and don't require someone else's participation, thank you.

Dominick: Well, IRH, as far as I'm aware I don't think there's a history of using it in emergency settings that I'm aware of. And there's a number of factors to be considered in training individuals, but also from the use of FABMS and fertility awareness methods in the past you can train lower [inaudible] [00:57:40] of women, or promoters or counsellors to disseminate the methods, and maybe that is an alternative but it would need to be tested at length.

Clifton: We are gonna come up very close to the inclusion of time for this webinar series and we are going to ensure that the presenters see the questions and the commentary and some of the follow up so they can respond to you individually. But the last question, before we transition over to the survey around the webinar is from Leslie, and she is asking can of the presenters speak about the challenges of data collection on FAM use. For instance, there are major challenges with identifying when people are using modern FAM as they are often misidentified as using rhythm methods or classified as used other methods. Dr. Polis could you respond to that?

Chelsea: Sorry, hello can you hear me?

Pia: Yes, we can hear you now.

Chelsea: So, yes to the question with the challenges and data collection and FABM use. I do think that it's challenging to ensure that we are obtaining accurate information in terms of which specific methods women are using. One I think, great example I can provide, and since we were just speaking a little bit about data and the NSFG, is the way that the most recent round of the NSFG did try to collect this date. And so, in addition to asking about the names of the specific methods, such as saying are you using calendar rhythm,

the NSFG actually uses language that describes the behaviors associated with use of each method.

And so, for rhythm they say, with this method a woman counts the days in her menstrual cycle to identify the days which she can get pregnant or unsafe days. They ask them separately about standard days methods or cycle beads, and they describe that as methods that identify days 8 to 19 of the cycle as days a woman can get pregnant or unsafe days. And then they ask separately about methods categorized under the grouping safe period by temperature or cervical mucus test, which they describe some names for these methods are, the **two-day** method, the billings ovulation method and the sympto-thermal method.

So, I think that one of the ways forward on ensuring that we have clear information about which specific methods are using, is to really use specific questions like this that help users identify themselves in to the correct category. Based either on recognition on the name of the method or the behaviors associated with that method.

Clifton: We are at time, we're gonna do one more question. If you need to drop off, please complete the survey on the screen and then we will be sending out links and further follow up. The last question we want to address is how can missions and bilaterals help get the cycle beads more available in the public sector, and we'll put those questions to both Adrienne and Dominick.

Adrienne: Thank you, I'm just going first because World Vision has really been a beneficiary of IRH's contributing 38,000 sets of cycle beads to the Ministry of Health in Kenya. And where they also were catalytic in distributing cycle beads in Uttar Pradesh. In Senegal we also used cycle beads, they were procured by the Ministry of Health. So, we find cycle beads wherever we have programs to be the case. Thank you.

Dominick: One of the things about the public sector and getting the cycle beads in to the public sector is motivation for the distribution channels. So, right now, we're testing a social marketing approach, social marketing distribution approach with a collaborator in Nepal, and working with them as they distribute methods such as Depo Provera and pills, they are community based change agents are also promoting and training people on raising awareness on standard days methods and cycle beads. And so, this kind of an approach is something that has happened in a few different

countries, I should say, with support from the missions.

And maybe one way to get it in to the public sector a little bit more. Also, I think, part of it could come back to training private sector or sorry, public sector providers around what the benefits are and if there is a clientele for these fertility awareness base. Not that often times they're disregarded due to alternative medical options, which might be the right methods for certain women, but maybe not for all. And having that large and more robust method mix will possibly bring as we've seen through the research, bring new women in to the group of women using family planning methods at the time.

So, there are different ways in which to kind of get it out there, whether it's public or private sector, but I think a lot of it comes to education. And educating both providers and people in the community in raising demand for these methods, as is done with all other methods, whether it's IUD or the pills.

Clifton:

Thank you very much. That's gonna complete our Q&A time, we certainly wanted to thank everyone for posing such thoughtful questions. Though this webinar does not represent the final opportunity to ask questions and do follow up. After this webinar you will be receiving a link with today's recording and in that recording, will be all of that information that you will need to contact individuals and you can review some of the questions for further reflection.

We want to thank each and every one of our presenters, Dominick, Chelsea, and Adrienne, all of you have brought such wonderful perspectives and you are to be commended for the work that you are doing in your respective locations. We look forward to research that's coming out as well as other programmatic improvements and guidance for future programming.

Final reminder, please fill out the two survey questions using the radio buttons and then type in any future webinars that you would like to see that will help with the improvements as well as future forecasting for this series with APC. Thank you to the APC project, IBP and to USAID and to each and every one of you for participating. It has been a grande experience.

[End of Audio]

Duration: 65 minutes