# FAM PROJECT
IRH GEORGETOWN UNIVERSITY

## Standard Days Method® (SDM) of family planning

Based on reproductive physiology, SDM identifies the days in the menstrual cycle when pregnancy is most likely, and thus, when to avoid unprotected intercourse. CycleBeads, a visual tool, helps women track their cycle to know when they are fertile. An efficacy trial showed SDM to be more than 95% effective with correct use and 88% effective with typical use, well within range of other user-dependent methods. The World Health Organization (WHO) recognizes SDM as an evidence-based practice and includes it in their family planning guidance documents. SDM is incorporated into national family planning norms and policies in over 20 countries around the world. More information is available at www.irh.org.

# Doing it right: Monitoring, Learning and Evaluating for Sustainable Scale-Up

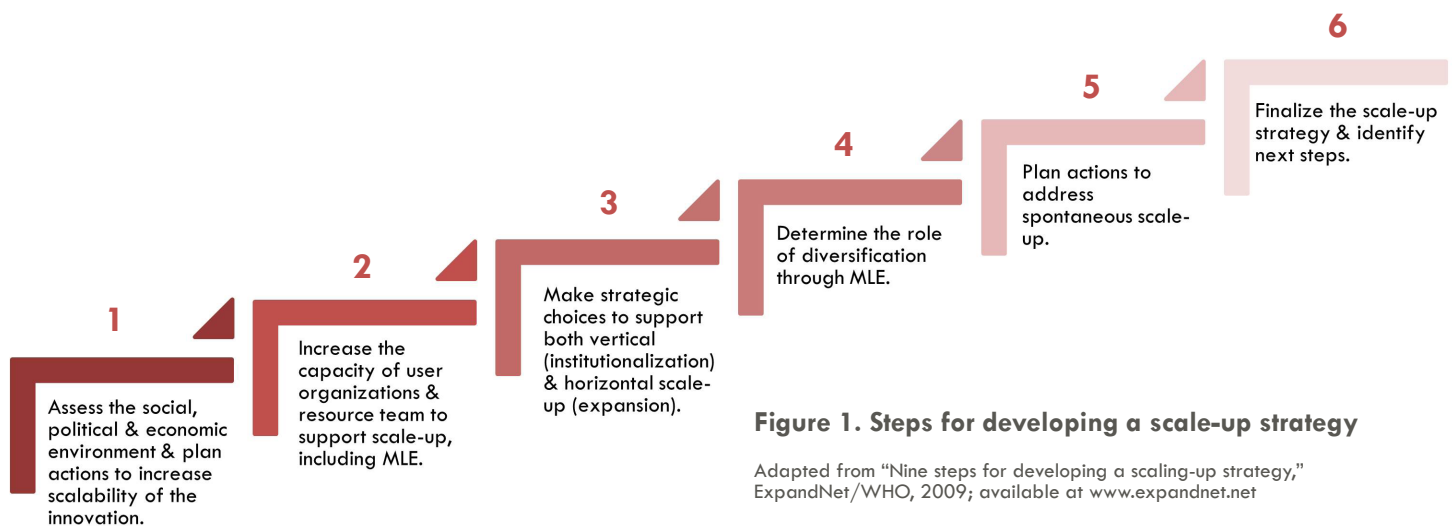## Why do some scale-up plans fail even with successful innovations?

Imagine a large country in the developing world called Florabora with three successful family planning (FP) pilot programs. Each was supported by bilateral or other outside donors. When the first pilot program had been completed, the implementer—an international non-governmental organization (NGO) with local branches—planned to scale it up to cover three more districts. However, a delay in follow-up funding meant that scale-up was not possible; even the original district reversed its gains when commodities and outreach workers were no longer affordable. Elsewhere in Florabora the dynamic, tireless director of another successful FP pilot program had trained four local health officials to introduce the program in their districts. When implemented, the program was not robust in these new sites and eventually died out. The organizers of the third FP program were pleased: as a result of their team's hard work, a new FP method had just been included in the national Ministry of Health (MOH) norms and also in training curricula. However, after a year, they were baffled by the fact that the new method was still not offered in most facilities.

Each of these tales reveals a truth about the challenge of scaling up and sustaining a successful pilot program. Scaling up must be strategically planned because it will not happen automatically or successfully, even when the merits of the pilot program become known to in-country officials and the professional community. Gaps in funding can be a fatal blow to expansion. Although leadership is important, if the pilot program's success depends on a single individual's personality, energy and commitment, efforts elsewhere to expand the innovation may not survive. Incorporating the new method in service delivery norms and training curricula is a step forward, but it is not enough for successful scale-up.

## The challenge: Doing it right

Working with implementation partners in five focus countries (Democratic Republic of the Congo (DRC), Guatemala, India, Mali, and Rwanda), Georgetown University's Institute for Reproductive Health (IRH) undertook the challenge of scaling up the Standard Days Method® (SDM) of FP (see sidebar)—and doing it right. IRH's approach differs from the above examples in important ways. Specifically, IRH has found that successful scale-up requires careful planning, a systems approach, evidence-based practices and flexibility as situations evolve. These are core principles of the ExpandNet/WHO framework of scaling up that IRH has adopted to guide the scale-up process. The framework also calls for transparency, effective partnerships, stakeholder involvement from the beginning, and supporting scale-up through research, monitoring, learning and evaluation (MLE) throughout the process.

**1** Assess the social, political & economic environment & plan actions to increase scalability of the innovation.

**2** Increase the capacity of user organizations & resource team to support scale-up, including MLE.

**3** Make strategic choices to support both vertical (institutionalization) & horizontal scale-up (expansion).

**4** Determine the role of diversification through MLE.

**5** Plan actions to address spontaneous scale-up.

**6** Finalize the scale-up strategy & identify next steps.

**Figure 1. Steps for developing a scale-up strategy**

Adapted from "Nine steps for developing a scaling-up strategy," ExpandNet/WHO, 2009; available at www.expandnet.net

ExpandNet emphasizes a crucial point: While successful pilots are the basis for scale-up, if the pilot is not designed from the beginning with expansion in mind, attempts to scale up the program in its initial form can hit roadblocks. IRH learned this reality following earlier efforts, including clinical trials and method introduction studies. These studies were meant to establish the effectiveness of SDM through rigorous scientific research and assess the feasibility of service delivery protocols. Further studies had tested strategies for integrating SDM into FP and other programs and addressed user and provider attitudes. Ultimately, this work led to the inclusion of SDM in WHO's contraceptive eligibility criteria and the guidelines of other respected reproductive health agencies. However, when the same screening and counseling protocols were used elsewhere during the first scale-up activities, MLE revealed them to be too complex. IRH adjusted protocols accordingly for each site using an iterative and step-by-step process (see Figure 1).

## How do research, monitoring, learning and evaluation support scale-up?

Within complex systems, unexpected events and their effect on the scale-up process or health outcomes may go unnoticed without frequent monitoring that pays careful attention to interrelationships and the change panorama. Therefore, MLE tools must be well-suited to capturing information relevant to guiding adaptation as part of scale-up. Increasingly, scale-up practitioners are turning to complexity-informed evaluation methods. These approaches take into account the dynamic environment in which health service innovations are expanded. This environment goes beyond the programs that serve clients. It includes the larger service delivery system and its many components (e.g., training, supervision, reporting, and procurement) and other factors such as the cultural, health and economic characteristics of families and communities; the needs and intentions of clients; the influence of media; the role of opinion leaders; and the policy climate on which approvals and financing depend.

At the same time, it is clear that focused MLE tools are needed to examine innovation fidelity—the extent to which essential elements of an innovation such as SDM are implemented during scale-up—and to monitor the scale-up process itself. Information in these two crucial areas—essential fidelity and needed adaptation—will reveal whether an innovation was successfully scaled up as it was intended. Additionally, ongoing monitoring of the scale-up process allows for problems to be worked out during implementation, such as unexplained delays in implementation. Without regular data informing the scale-up process, an innovation may fail in the new environment and the resource team[1] may never know why.

## IRH tools offer guidance

Based on these insights, IRH's approach is to operationalize the critical indicators of scale-up and then use a manageable semi-annual process to monitor benchmarks. To do this, IRH has developed a package of practical tools to research, monitor and evaluate scale-up of a new FP method such as SDM (see Table 1). The package includes both quantitative and qualitative instruments for monitoring and evaluating the various domains of scale-up. Many of these measures provide evidence for mid-course adjustments and decisions; others provide endline results.

For example, IRH uses household and facility surveys, service statistics, commodity reports, and benchmark reporting, among other measures, to assess coverage and sustainability. It also uses focus groups, in-depth interviews and an inductive qualitative method called Most Significant Change (MSC) Stories to document and understand the scale-up process (see box). MSC asks various stakeholders: what are the most significant changes that have occurred as a result of adopting the innovation (e.g., SDM)? The answers can bring to light not only what happened but the meanings of scale-up processes and outcomes to partner organizations,

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[1] The group of organizations that facilitates wider use of the innovation and has interest and ability to provide technical assistance and resources to other organizations to utilize the innovation at scale

providers, women, couples and communities. MSC can also elicit intangible and unanticipated aspects of scale-up not detected by quantitative methods, such as any negative effects of the innovation on other elements of the system. Further, it helps those involved to reflect on the values and goals at the heart of scale-up, for example, whether the intrinsic values of the innovation were maintained during scale-up. Across countries, the majority of most significant changes among SDM users, providers and administrators were positive.

Table 1 (below) summarizes the range of MLE tools IRH has used to measure scale-up outcome, output and process indicators. They apply to these domains: 1) the coverage and sustainability of SDM availability and use, which can only be measured over time as the innovation spreads geographically and becomes institutionalized; 2) the process and quality of the scale-up, i.e., whether it proceeds at reasonable pace and is appropriately adapted yet faithful to the essential operational definition of SDM delivery and use; and 3) the inherent values of SDM, such as gender equity and attention to human rights, and whether they are maintained when expanded beyond the pilot phase.

## Case studies: How is scale-up working in various settings?

With its many in-country partners, IRH implemented five-year prospective studies of scaling up SDM in DRC, Guatemala, India, Mali, and Rwanda, guided by the ExpandNet model. In each country, the first goal was to assess horizontal scale-up, i.e., access to SDM services at the national or near-national level. The second goal was to determine the degree of vertical scale-up:

### Most Significant Change Stories (MSC)

The MSC technique was used in the multi-country scale-up case study. It began with a simple question to clients, providers and FP administrators: "Looking back over the past year, what do you think is the most significant change in your life as a result of your involvement with the Standard Days Method?" A user might reply, "My husband and I now communicate about sex without embarrassment" or "My husband was always angry when asked to refrain from sex during the fertile period." Providers might say, "I feel proud that I can offer a method that couples who did not use FP before can use." An administrator might report that overall demand for FP services has risen, while another might report that revising the guidelines to include SDM was burdensome. The interviewer then asks a follow-up question: "Why do you think this change was significant?" Using a participatory process, one level of an organization selects the most significant accounts of change from among the many stories collected and sends them up to the next level. This process is repeated until a small number of commonly identified significant changes is distilled, analyzed for actionable implications and reported back to stakeholders, including those who can take action to reinforce the positive and address negative findings.

integration of SDM into FP norms, policies, service and supervision guidelines, curricula, reporting systems, procurement lines, and health promotion activities. Each scale-up country developed end-of-project performance benchmarks to track progress over time. Although each scale-up context is different, all five countries made great progress. Countries were strongest on incorporating SDM into policies, training and IEC initiatives. However,
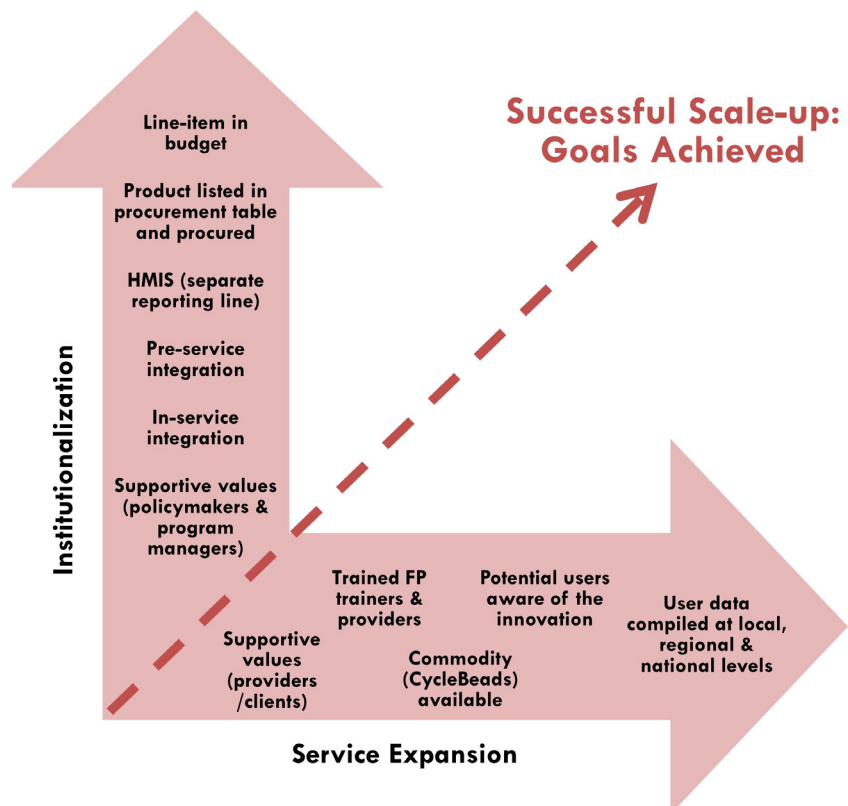
| Indicator Type | Measurement Tools | Domain | | | | |
|---|---|---|---|---|---|---|
| | | Coverage | Sustainability | Process | Quality | Values |
| **Outcomes**<br>• Awareness & use of SDM<br>• Availability of quality services<br>• Provider competency | Household Survey | | | | | |
| | Service Statistics, Reports on sales and stock-outs | | | | | |
| | Most Significant Change (MSC) Story Collection | | | | | |
| | Knowledge Improvement Tool & Client Follow Up | | | | | |
| **Outputs**<br>• Providers trained<br>• Clinics offering SDM<br>• Demand-oriented IEC<br>• Supportive partners & stakeholders<br>• Systems integration | Facility/Service Delivery Point (SDP) Survey | | | | | |
| | Stakeholder Interviews | | | | | |
| | Benchmark Reporting | | | | | |
| **Process**<br>• Scale-up strategy<br>• Types of scale-up<br>• Dissemination and advocacy<br>• Capacity building<br>• Organizational processes<br>• Resource mobilization<br>• Environmental influences | Focus Group Discussions with IRH staff | | | | | |
| | Events Timeline | | | | | |

**Table 1. Tools to facilitate analysis of scale-up domains**

efforts are still needed to ensure that SDM is reported at all levels of health management information systems, in logistics and procurement systems (for CycleBeads), and in national surveys. Mali and Rwanda achieved near-national availability of SDM services and the state of Jharkhand in India integrated SDM into health facilities that serve 12 million people. Guatemala laid the foundation for future nationwide SDM availability by demonstrating interest in and demand for SDM in a targeted region. DRC, which adopted an approach of post-conflict family planning revitalization, has scaled up to two-thirds of the country's health zones. All five countries will require continued advocacy and capacity-building to sustain SDM scale-up (see Figure 2).

**Figure 2. Monitoring institutionalization and expansion: Example of integration of a new FP method**



**Institutionalization**

- Line-item in budget
- Product listed in procurement table and procured
- HMIS (separate reporting line)
- Pre-service integration
- In-service integration
- Supportive values (policymakers & program managers)

**Service Expansion**

- Supportive values (providers/clients)
- Trained FP trainers & providers
- Commodity (CycleBeads) available
- Potential users aware of the innovation
- User data compiled at local, regional & national levels

**Successful Scale-up: Goals Achieved**

## Top ten tips for successful scale-up

Based on its experiences in Africa, Asia and Latin America, and the guidance of the ExpandNet model, IRH recommends the following actions:

1. Develop and implement the pilot program with expansion in mind.

2. To sustain scale-up, secure multiple partners and long-term funding –requirements often overlooked by donors and participating organizations alike.

3. Work with stakeholders from the beginning to define the innovation clearly, have a concrete vision of scale-up success, and identify specific indicators and benchmarks.

4. Achieve an appropriate balance between vertical and horizontal scale-up.

5. Focus MLE on the pace of expansion, needed adaptations, and essential fidelity to the innovation, including its inherent values.

6. Prior to and throughout the scale-up process, identify needed adjustments and course corrections in the new sites, maintain momentum and accountability, and build strategic planning skills among stakeholders.

7. While adaptation is necessary, replicate the essential features of the successful pilot when scaling up (i.e. research-based planning, a systems approach, partnering with relevant organizations, diverse stakeholders, varied providers and communication with policymakers).

8. Operationally define indicators for access to the new FP method and its integration into health programs within the context of the healthcare delivery system.

9. Involve multiple partners in research and MLE to engage stakeholders, increase their commitment, and build their research skills.

10. Balance research and programmatic needs; this balance is more likely to produce relevant, timely data for stakeholders with diverse needs.