AWARENESS Project
Rwanda Country Report
2002–2007

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The *Institute for Reproductive Health*, affiliated with Georgetown University in Washington, D.C., is a leading technical resource and learning center committed to developing and increasing the availability of effective, easy-to-use, natural methods for family planning.

The purpose of the AWARENESS Project was to improve contraceptive choices by expanding natural family planning options and developing new strategies and approaches to increase the reproductive health awareness of individuals and communities in developing countries.

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TABLE OF CONTENTS

Acronyms

ARBEF	Rwandan Family Welfare Association
BCC/IEC	Behavior Change Communication/Information, Education, and Communication
CA	Cooperating Agency
CBD	Community-based Distributor
CAMERWA	Central Commodities Warehouse
CHM	Community Health Mobilizers
CPT	Contraceptive Procurement Table
DHS	Demographic and Health Survey
FAB	Fertility Awareness-based Method
FBO	Faith-based Organization
INSR	National Statistics Institute
IPPF	International Planned Parenthood Federation
IRH	Institute for Reproductive Health
KIT	Knowledge Improvement Tool
LAM	Lactational Amenorrhea Method
MIS	Management Information System
MOH	Ministry of Health
NGO	Non-governmental Organization
ONAPO	National Population Office
SDM	Standard Days Method®
TDM	TwoDay Method®
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

The AWARENESS Project
Expanding Family Planning Choices Worldwide

Country Program Summary
Rwanda

November 2007

Country Context

Rwanda is a densely populated country in Central Africa with 8.6 million people, most of whom live in rural areas. Preliminary data from the 2005 Demographic and Health Survey (DHS) report showed an increase in modern contraceptive prevalence to 10.3% from under 4% in 2000.[1] Use of modern methods is still below the 13% recorded prior to 1994.[2] The percentage of married women who want no more children rose from 33% in 2000 to 42% in 2005, and 39% of women would like to space births with at least two-year intervals.[3] The AWARENESS Project implemented activities in Rwanda between 2002 and 2007, beginning with operations research on the Standard Days Method® (SDM), conducted in partnership with USAID-supported projects implemented by IntraHealth and with the Rwandan Ministry of Health (MOH). Building on this experience, the SDM is now being integrated into family planning services on a larger scale.

Approach

- Examine facility and provider capacity to add the SDM to the method mix, method acceptability to providers, and providers' willingness to offer it to clients.
- Monitor provider performance, including ability to counsel clients in SDM use.
- Determine client acceptance and continuation of the method.
- Build capacity and commitment for full integration and scale-up of the SDM in the national program.

Activities

- Implementing feasibility studies to expand the evidence base for providing the SDM.
- Developing partnerships with the MOH, USAID cooperating agencies (CAs), and indigenous nongovernmental and faith-based organizations (NGOs and FBOs) to introduce and scale-up the SDM within existing services.
- Strengthening government capacity to sustain SDM services by working with the national management information (MIS) and logistics systems and providing assistance to the training and supervision departments.

Key Results

Approximately 800 providers have been trained to offer SDM services, and the method is now available at more than 400 sites. MOH statistics show over 6,000 registered SDM users (5–12% of new family planning clients in sites where the method is offered), with the number of new users growing rapidly. Over 95% of clients choosing the SDM have not used family planning previously. Progress also has been made in including the SDM in policies and norms and in other support systems.

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Research:

SDM Pilot Study: This study assessed the status of SDM use after one year of service delivery.

- Over 90% of women and their partners found it easy to manage the 12-day fertile period.
- Over 20% of couples combined SDM with condom use.
- Providers and clients found the method easy to teach, learn and use.
- Over 90% of SDM users correctly identify the fertile days, compared to 9% of women interviewed in the 2000 DHS. [4]

Large-Scale SDM Integration into Public Reproductive and Child Health Services: This multisite, international study measured the effect of offering the SDM in a concentrated geographic area over a 25-month period, including three rounds of simulated clients, time series collection of service statistics, and an endline survey.

- Providers adequately counseled clients in a single counseling session.
- Some providers posed unnecessary medical barriers to SDM use.
- Frequent staff rotation at health centers resulted in decreased service quality.
- The number of new SDM users per quarter increased over time.

Community Health Mobilizers Assessment: This study assessed this cadre's knowledge and attitudes about the SDM. Results showed that community health workers are as competent as clinic-based health workers at informing people about the method. The availability of quality SDM services could be increased significantly if community-based workers were allowed to offer the method.

TwoDay Method® Pilot Introduction: This study examined the feasibility of integrating the TDM with the current family planning method mix of two African faith-based organizations, including Action Familiale Rwandaise (AFR). Trained teachers understood the method and found it easy to use and explain.

When women reacted negatively to other modern methods, we felt helpless. Now, women are satisfied with the SDM, and we are proud.

Mayange community health worker

SDM Integration:

Initially, IRH cost-shared with USAID CAs and smaller indigenous for training and purchase of CycleBeads®. The main CAs now allocate substantial resources to ensure full integration of the SDM in their services. UNFPA co-funded scale-up activities in its program regions. Action Familiale also covers most of the cost of integrating SDM into their efforts.

IRH successfully collaborated with PRIME-II to include the SDM in the in-service training curriculum and with the Capacity Project to integrate it into the draft pre-service curriculum awaiting MOH approval. IRH and the MOH collaboratively trained almost 2,000 community health workers to inform the population about the SDM, among other methods.

Over the past two years, IRH shifted capacity building efforts to focus on sustainability, providing assistance to in-country organizations with specific mandates in reproductive health—such as the IPPF affiliate, ARBEF, and the two USAID-funded family planning/reproductive health projects in the country. Long-term SDM programming capacity now exists in the MOH; the IntraHealth Twubakane and Capacity projects; and the local IPPF affiliate, *Association Rwandaise Pour le Bien-Être Familial*.

The SDM was included in the new Family Planning Strategy and Sub-Policy presented to Parliament in June 2005 and listed separately as a modern method in the analysis of 2005 DHS data.

IRH succeeded in incorporating the SDM into various behavior change communication (BCC) efforts, all within the framework of the national strategy. The program had particular success in

attracting media attention for the SDM, including the incorporation of the SDM in the ongoing story line of a popular radio soap opera supported by the BBC World Education Trust. IRH also regularly collaborated with both UNFPA and WHO to include articles on the SDM in their publications and ensured that the SDM was included in all national, government-approved educational materials.

Following a phased process, the SDM is now becoming integrated in national MIS and forecasting, logistics, and distribution systems.

Lessons to Guide Future Programming

- Addressing SDM integration within the context of large-scale CA programs was critical to success, allowing considerable leveraging.
- One of the biggest obstacles has encountered in Rwanda is a persistent, if unstated, bias against natural methods among some decision makers, policymakers and providers. This underscores the importance of ongoing research and advocacy.
- As sites expand, there is a need to roll targeted awareness-raising efforts into the broader IEC/BCC mandate of another CA and/or the government program.
- While indigenous training capacity exists, to ensure SDM is integrated fully into the range of methods offered, providers need more intensive supervision and follow up.
- Frequent turnover of health workers affects the ability of sites to maintain quality services. Future efforts should train multiple workers in each locale.
- The SDM can be incorporated into community-based distribution programs and marketed in pharmacies and private clinics.
- Although CycleBeads are now part of the national logistics and distribution system, further attention should be paid to include them in tracking forms used to estimate contraceptive commodity needs.
- There is a need to support and monitor the effectiveness of integration into national support systems, e.g., MIS, procurement and distribution, norms and protocols, pre-service curricula.
- Potential exists for revitalizing use of the Lactational Amenorrhea Method (LAM) and expanding the integration of the TDM into existing services.

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[1] *Institut National de la Statistique du Rwanda (INSR) and ORC Macro. 2006. Rwanda Demographic and Health Survey 2005. Calverton, Maryland, U.S.A.: INSR and ORC Macro; and Office National de la Population (ONAPO) [Rwanda] and ORC Macro. 2001. Rwanda Demographic and Health Survey 2000. Kigali, Rwanda and Calverton, Maryland, USA : Ministère de la Santé, Office National de la Population and ORC Macro.*

[2] *Office National de la Population (ONAPO) [Rwanda] and ORC Macro. 1994. Rwanda Demographic and Health Survey 1992. Kigali, Rwanda and Calverton, Maryland, USA : Ministère de la Santé, Office National de la Population and ORC Macro.*

[3] *Institut National de la Statistique du Rwanda (INSR) and ORC Macro. 2006.*

[4] *Correct knowledge of the fertile time is defined in the DHS as women who respond that they are most likely to get pregnant during the middle of their cycle, much less precise than the fertile time indicated by the SDM.*

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I. Introduction

Source: CIA World Factbook 2008

Rwanda is a small, densely populated country in Central Africa with 8.6 million people, most of whom live in rural areas. Preliminary data from the 2005 Demographic and Health Survey (DHS) showed an increase in modern contraceptive prevalence to 10.3% from under 4% in 2000.[1] While this increase is a positive sign, use of modern methods is still below the 13% recorded prior to the 1994 genocide.[2] The percentage of married women who want no more children rose from 33% in 2000 to 42% in 2005, and 39% of women would like to space births with at least two-year intervals.[3] Thus, increased access to effective, easy-to-use methods of family planning is critical.

In June 2002, the USAID Mission in Rwanda invited the Georgetown University Institute for Reproductive Health (IRH) AWARENESS Project to work with PRIME II (IntraHealth) and the Ministry of Health (MOH) to introduce the Standard Days Method® (SDM) into existing family planning services. The goal was to address unmet need for family planning in Rwanda by increasing access to and use of fertility awareness-based (FAB) methods of family planning, particularly the SDM, as part of the contraceptive method mix. The project began in late October 2002 by selectively integrating the SDM into 13 public, faith-based (Catholic and Protestant) and nongovernmental clinics. Prior to initiating training and service delivery activities, the MOH hosted an orientation session to introduce all in-country reproductive health partners, including the United Nations Population Fund (UNFPA), World Health Organization (WHO), the Rwandan Family Welfare Association (ARBEF), USAID cooperating agencies (CAs,) and local nongovernmental organizations (NGOs) to the SDM and the planned pilot activities. IRH followed up this orientation session with individual meetings with key partners. The project hired a local coordinator, secured office space, trained providers and supervisors from the 13 pilot sites (selected in consultation with the MOH, IntraHealth, and the mission) and provided them an initial supply of CycleBeads® and job aids. The 13 sites were all in USAID priority areas and part of IntraHealth's network.

Over the next three years, the project slowly expanded, directly supporting the introduction of the SDM into 69 sites. IRH's local office trained providers, conducted monitoring and supervision, gathered service statistics, and provided sites with CycleBeads. After the pilot phase, IRH began to transfer capacity to the MOH and in-country organizations and CAs, including the IntraHealth Twubakane and Capacity projects, and ARBEF, the local affiliate of the International Planned Parenthood Federation (IPPF). The program conducted several studies, including a first-year assessment, a study of the impact of SDM introduction, and an informal qualitative assessment of health mobilizers. The results of these studies indicated demand for the SDM, given that over 6,000 clients were registered users as of June 2007, representing five to

[1] Institut National de la Statistique du Rwanda (INSR) and ORC Macro. 2006. *Rwanda Demographic and Health Survey 2005.* Calverton, Maryland, U.S.A.: INSR and ORC Macro; and Office National de la Population (ONAPO) [Rwanda] and ORC Macro. 2001. *Rwanda Demographic and Health Survey 2000.* Kigali, Rwanda and Calverton, Maryland, USA : Ministère de la Santé, ONAPO and ORC Macro.
[2] Office National de la Population (ONAPO) [Rwanda] and ORC Macro. 1994. *Rwanda Demographic and Health Survey 1992*. Kigali, Rwanda and Calverton, Maryland, USA : Ministère de la Santé, Office National de la Population and ORC Macro.
[3] Institut National de la Statistique du Rwanda (INSR) and ORC Macro. 2006.

12% of new family planning clients in sites where the method was offered. Results also showed that clients could correctly use the method and that they tended to use condoms during the fertile days. Of note is the fact that the method attracted new family planning users; over 95% of clients choosing the SDM had not used family planning previously.

IRH first received field support from the mission for the 2004–2005 fiscal year; field support continued through the 2007 fiscal year.

II. Objectives and Strategy

The original project objective in Rwanda was to determine the acceptability and appropriateness of the SDM. In particular, the team set out to examine facility and provider capacity to add the SDM to the method mix, the extent to which providers would accept this new method, and their willingness to offer it to clients. The project also aimed to monitor provider performance in SDM provision, including ability to counsel clients to use the method correctly as well as client acceptance, satisfaction, and continuation of the method. The strategy was to begin on a pilot basis in 13 sites chosen in conjunction with partners. IRH and partners planned and coordinated all activities collaboratively so as to facilitate understanding of SDM services and to encourage partner ownership of the process. With so few sites, IRH and partners were able to carefully plan trainings and activities and closely monitor and follow up services, emphasizing assessment and evaluation of provider capacity and client interest and ability to use the method correctly. While partners were interested in the SDM, they wanted to see results before committing to a larger scale up of the method. In 2003, IRH conducted an assessment of the 13 pilot sites, which demonstrated positive results (see ***Research*** section). At that point, the MOH and partners decided to expand the pilot intervention to an additional 15 sites in the country. After positive results from these pilot sites, more sites were gradually added. Toward the end of 2006, the MOH and USAID requested full integration and scale up of the SDM in the country.

IRH's strategy shifted from demonstrating acceptability and feasibility to strengthening systems to support the long-term availability of the SDM, and transferring capacity to partners to continue service expansion. IRH maintained regular contact with the 69 sites directly overseen by the AWARENESS Project, providing them with supervision; behavior change communication/information, education, and communication (BCC/IEC) materials, and CycleBeads. However, IRH simultaneously provided increased technical assistance to partners taking on responsibility for SDM service delivery in their respective activity areas. IRH also began to focus on strengthening government capacity to sustain SDM services by working with the national management information system (MIS), the logistics system, and training and supervision departments.

III. Activities and Accomplishments

To achieve project objectives, IRH worked closely with the MOH, USAID CAs, and local organizations to train trainers, supervisors, and providers; adapt existing client, provider, and promotional materials to the Rwandan context and language; conduct BCC activities at the community level and organize orientation sessions for community and religious leaders; conduct regular supervision visits; collect and analyze service statistics; purchase and supply CycleBeads

to partners; participate in national family planning working groups/committees; and conduct focused research.

Once the project objectives expanded toward full integration and sustainability, IRH shifted from directly conducting activities to providing technical assistance and support to partners to execute those activities. IRH often shared tools and materials with partners and encouraged cost-sharing of their production. To support the long-term availability of SDM services, IRH worked with the central procurement and distribution department to integrate CycleBeads with other commodities in the system. It coordinated with the government to include the SDM in the national pre- and in-service training materials and facility-level tools and materials such as family planning registers and client cards. The project continued to collect service statistics, conduct focused research, and participate on national family planning task forces/committees. BCC/IEC activities to increase knowledge of the SDM at the community level used channels including community health workers, radio shows, and community talks. The table below summarizes the key partners over the life of the project and the various activities undertaken with each.

> *"When women reacted negatively to modern methods, we felt helpless. Now, women are satisfied with the SDM and we are proud".* -
> **Mayange community health worker**

Table 1: Summary of Partners and Activities

Collaborating Organizations	Activities Undertaken	Partner's Role	IRH's Role	Accomplishments
Ministry of Health (MOH)	• Training of trainers • Training of providers • Supervision • Coordination of all research activities • Implementation of first-year assessment • Participation on national family planning committees and task forces • Integration into the MIS of pilot sites • Integration of SDM into central commodities warehouse (CAMERWA) and distribution system • Inclusion of SDM in policy documents • Community mobilization activities	• Coordinate activities/logistics, including regular meetings • Help with data collection • Participate in supervision visits • Approve research protocols • Assist in conducting assessment • Include IRH in policy meetings and decisions relevant to SDM	• Initiate activities and collaborate with MOH for approval and input • Partially finance activities • Provide all materials for trainings, including CycleBeads • Conduct trainings • Lead supervision visits • Collect data • Coordinate first-year assessment • Provide information for inclusion in policy documents • Actively participate in meetings • Train community health mobilizers (CHMs) and provide with appropriate tools • Supervise CHMs	• SDM in the national family planning policy • Cadre of SDM trainers available (22) • Large number of providers trained in SDM (388) • Large number of CHMs trained (1,932) • Number of SDM users increasing • CycleBeads included in CAMERWA and in revised tracking tools • SDM routinely included in national BCC/IEC efforts and materials • Several studies conducted and results disseminated, including first-year assessment

Collaborating Organizations	Activities Undertaken	Partner's Role	IRH's Role	Accomplishments
IntraHealth PRIME II	• Training of providers in 13 pilot sites • Inclusion of SDM in national family planning training guide • Contraceptive technology update in impact study sites	• Participate in selecting pilot sites • Coordinate training logistics	• Lead coordination of training • Provide all materials for trainings, including CycleBeads • Lead supervision visits	• Providers in 13 pilot sites trained • Supervision visits conducted • SDM included in national family planning training guide
Rwandan Family Welfare Association (ARBEF)	• Training of providers in one clinic • Training of community-based distributors (CBDs) in one site • Supervision • Training additional providers in seven clinics	• Coordinate trainings with IRH • Supervise providers and CBD workers	• Train providers • Provide all materials for trainings, including CycleBeads • Conduct supervision visits • Assist ARBEF to access CycleBeads at CAMERWA	• Total of 26 providers trained in SDM • Total of 119 CBDs trained in SDM
IntraHealth Twubakane	• Training of providers in 92 sites • Training of trainers at national level • Supervision	• Organize trainings • Purchase CycleBeads and produce training materials and provider tools • Coordinate supervision visits	• Conduct trainings • Provide electronic versions of tools and materials • Assist with supervision visits	• 110 providers trained • Supervision visits conducted • Materials distributed
IntraHealth Capacity	• Training of providers in 120 sites • Training of trainers at national workshop • Supervision	• Same as above • Integrate SDM into pre-service curricula being developed with MOH	• Same as above • Provide information to include in pre-service curricula	• 158 providers trained • Supervision visits conducted • Materials distributed • SDM included in pre-service curricula
Population Services International	• Orientation of staff on SDM • Inclusion of SDM in BCC/IEC activities on ad hoc basis	• Approach IRH with any need for information or materials • Inform IRH of opportunities to integrate SDM into mobilization activities	• Provide requested materials • Assist in mobilization activities on ad hoc basis	• Various mobilization activities conducted
John Snow, Inc. DELIVER Project	• Inclusion of CycleBeads in Contraceptive Procurement Table (CPT) • Tracking of CycleBeads distribution and consumption	• Assist government to integrate CycleBeads in existing contraceptive forecasting, tracking, and logistics system	• Assist DELIVER to integrate CycleBeads into current logistics system, including past service statistics collected by IRH	• CycleBeads housed at the CAMERWA • CycleBeads tracked among other commodities by DELIVER and the government • CycleBeads included in the Rwandan CPTs

	• Inclusion of CycleBeads in RHInterchange database used by government			• CycleBeads soon to be included in the RHInterchange database
Action Familiale	• Training of trainers in SDM in all dioceses • Adaptation of faith-based SDM materials • Training of teachers in the TwoDay Method® (TDM) in two dioceses • Provision, translation, and adaptation of TDM materials • Refresher TDM training	• Organize trainings—both SDM and TDM • Co-train on TDM • Identify sites for TDM introduction • Translate and adapt TDM materials • Organize refresher training for TDM	• Conduct SDM training • Co-train on TDM • Provide all materials—both SDM and TDM • Funding trainings	• 14 trainers trained in SDM • 18 teachers trained in TDM

A. Research

i. First-year assessment

Provider training in the District of Gicumbi, February 2005.

The project in Rwanda began as an assessment pilot to determine whether to scale up SDM services. This assessment was conducted in late 2003 after the first year of the program. It consisted of a series of key informant interviews and focus group discussions with SDM clients (both women and their partners) and with service providers. Additional focus groups were held with men and women in the community to determine whether SDM messages had reached them and to provide information on community attitudes toward the method. Finally, staff made efforts to locate and interview women who had been using the SDM and reported a pregnancy to explore likely causes of failure. Half of those women reported that they had planned the pregnancy and another third had had more than two cycles out of range (26-32 days) but continued using the SDM.

Key findings from the report include:

- Less than 5% of SDM users had previously used family planning.
- Over 90% of women and their partners found it is easy to manage the 12-day fertile period.
- Over 20% of couples combined SDM with condom use.
- Between October 2002 and September 2003, 801 clients adopted the SDM.
- Providers found the method easy to teach and to learn.
- Clients found the method easy to learn and to use.

- Over 90% of SDM users could correctly identify the fertile days, compared to 9% of women interviewed in the 2000 DHS.[4]

With results clearly showing the acceptability of the method to providers and clients and clients' ability to use the method correctly, USAID, the MOH and IntraHealth selected an additional 15 sites to offer the SDM. IRH continued to provide technical assistance and support to these sites and to monitor provider competency via regular supervision visits and applications of the Knowledge Improvement Tool (KIT), a skills assessment tool developed by IRH to assess provider competency.

ii. Impact study

Positive results from this assessment were also partly responsible for the decision to include Rwanda as one of three sites for the Impact Study. The Impact Study was designed to measure the effect of offering the SDM in a concentrated geographic area over a 24-month period, from October 2004 to October 2006. The study comprised 39 health centers, 20 in the intervention area and 19 in the control area. It included three rounds of simulated clients, time series collection of service statistics, and an endline survey of SDM knowledge, attitudes, and use.

Results from the simulated client visits indicated that providers adequately informed clients about the SDM and that SDM counseling took less than 30 minutes. Most providers encouraged informed choice, meaning they presented all available methods and did not attempt to sway the client once a choice was made. According to service statistics, the number of new family planning users increased in both the intervention and control sites during the period of the intervention. Finally, the endline survey showed that about two-thirds of men and women in the intervention area had heard of SDM and most found it an acceptable method.

The findings of the impact study also shed light on certain programmatic strengths and weaknesses, which IRH and the government subsequently addressed through refresher trainings and supervision, including:

- Some providers erected unnecessary medical barriers to SDM use such as requiring that the woman be menstruating or accompanied by her husband at the time of the visit.
- Frequent staff rotation at health centers resulted in decreased quality of family planning services, in particular the SDM, probably because it is not routinely included in pre- and in-service training.
- The number of new SDM users per quarter increased over time.

iii. Community health mobilizers assessment

In late 2006, IRH conducted an informal qualitative assessment of the knowledge and attitudes of community health mobilizers (CHMs) trained to offer SDM information and referrals. (CHMs are not allowed to provide the SDM). An IRH team led by an independent consultant interviewed 45 CHMs and conducted eight focus group discussions with a total of 70 participants, with equal

[4] Correct knowledge of the fertile time is defined in the DHS as women who respond that they are most likely to get pregnant during the middle of their cycle, much less precise than the fertile time indicated by the SDM.

numbers of men and women represented throughout. In general, no significant differences were found between the abilities and attitudes of male and female CHMs. The majority of CHMs scored above 80% on an SDM competence test, and felt very comfortable discussing the SDM with community members, including issues such as menstruation, fertility, and sex. Many CHMs gave examples of strategies they had developed, such as using personal experience and emphasizing the confidential nature of the discussion. The 115 CHMs involved in this informal assessment estimate that they reached nearly 3,600 people with messages about the SDM. These results are consistent with results of studies conducted in other countries showing that community health workers are as competent as clinic-based health workers at informing people about the SDM. It also suggests that the availability of quality SDM services could be increased if CHWs were allowed to offer the method.

iv. TDM pilot introduction

The TDM, developed by IRH, relies on noticing the presence or absence of cervical secretions to determine whether or not a woman is fertile each day. This method is appropriate for women with irregular cycles or those who prefer a fertility awareness-based method tailored to their own cycle. Results from an efficacy study showed that the TDM is more than 96% effective when used correctly. Moreover, the results from the efficacy trial suggest that the method is: (a) acceptable to women, men, and providers, (b) easy to teach, learn, and use, and (c) viable to offer in regular health and family planning services.

However, before any new method is offered widely, it is important to collect information that will guide its introduction and, if appropriate, expanded and routine provision. Given the central role that faith-based organizations (FBOs) play in providing family planning services in Africa, IRH designed a study to examine the feasibility of integrating the TDM into the current family planning method mix of two FBOs in Africa—an issue raised during the clinical trial—and to document the approaches taken by those organizations to introduce the method.

IRH began working with Action Familiale Rwandaise, an organization founded in 1985 by the Rwanda Catholic Bishops Conference, to pilot the TDM as part of this research study. The study consisted of two phases: a preliminary phase of training, small-scale service provision and feedback, followed by formal service delivery, client recruitment, client interviews and data collection. IRH trained Action Familiale's teachers in the TDM in May 2007. Teachers began using the method themselves, and soon after they began offering it to clients. An informal meeting and refresher training revealed that teachers understood the method and found it easy to use and explain. Focus group discussion at the end of August 2007 more formally explored teachers' experiences using and teaching the method, to inform the research protocol for the second phase of the study.

Preliminary F6 results suggest that providers learned how to provide the TDM correctly, but remain somewhat skeptical about offering the method to women with lower education levels. More research is needed on reducing provider barriers and the method's effectiveness.

B. Building awareness of and support for the SDM

> *"The MOH wants to see this method made available at every point of service delivery".*
> **.– Dr. Solange Hakiba, MOH, Rwanda, Coordinator of MCH Task Force and Family Planning Technical Working Group**

IRH held numerous advocacy meetings with policymakers throughout the project, including dissemination of research results, in order to obtain and maintain their commitment to including the SDM in their programs. Through these meetings, IRH became an integral part of the family planning community in Rwanda, participating in several national task forces and committees, such as the repositioning family planning committee, the IEC committee, the Maternal/Child Health Task Force, and the Family Planning Technical Working Group. Participation in these national groups helped ensure inclusion of the SDM in the new Family Planning Strategy and Sub-Policy presented to Parliament in June 2005. The strong partnership with the MOH and IntraHealth also led to the SDM's inclusion in the national pre- and in-service family planning curricula and ensured that the SDM was listed separately as a modern method in the analysis of 2005 DHS data.

In addition to advocacy with policymakers, program managers, and clinic staff, local staff organized orientation sessions with community and religious leaders to gain their support for the SDM. In order to increase awareness among potential clients, IRH conducted various BCC/IEC activities, all within the framework of the national IEC strategy. Of particular note is the success in attracting media attention for the SDM. IRH staff appeared as guests on local radio and television shows, invited journalists to meetings, organized media workshops, and published articles in the popular press. By creating media interest, IRH was able to interest the producers of a popular radio soap opera supported by the BBC World Education Trust to include the SDM in its ongoing story line. IRH also regularly collaborated with both the UNFPA and the WHO to include articles on the SDM in their publications.

CHW training in Manyagiro, Disctrict of Gicumbi, June 2005

IRH ensured that the SDM was included in all national, government-approved IEC materials, such as multimethod posters. IRH also produced additional promotional and educational materials, particularly those geared towards attracting and involving men in family planning decisionmaking. The project produced many materials in the local language, Kinyarwanda, to make them accessible to more of the population.

Finally, IRH worked with the MOH to train a large cadre of community health workers (1,932) to inform the population about the SDM, among other methods.

It seems likely that these combined efforts contributed to the fact that about a third of Rwandan men and women reported that they had heard of the SDM in the 2005 DHS (34% of all women and 40% of all men).

C. Developing the capacity of local organizations

In collaboration with the government, IRH began working in Rwanda by directly providing technical assistance to a small number of health centers. This pattern is unlike other countries, where IRH more often provides technical assistance to other local and international organizations supporting service delivery sites. In the early years in Rwanda, IRH focused on building capacity within the staff of those centers, MOH policymakers, and managers. At the beginning of the project, IRH trained a cadre of 22 government trainers (see Table 2 below). IRH then conducted provider trainings, using those trainers and further building the government's capacity to sustain SDM training. Similarly, IRH conducted visits with government supervisors in an effort to build their capacity in supportive SDM supervision, usually using the KIT. The results of those visits then determined exact needs for refresher training. IRH collected service statistics directly from the health centers offering the SDM and shared the data with the government. As of June 2007 (the last month that IRH collected service statistics for the AWARENESS Project), 69 sites had registered nearly 6,085 clients over a period of approximately four years.

Over the past two years, IRH began to shift capacity-building efforts, providing assistance to in-country organizations with specific mandates in reproductive health—such as the IPPF affiliate, ARBEF, and the two USAID-funded family planning/reproductive health projects, the Capacity and Twubakane projects—and to those with wide community reach, such as the Catholic FBO, Action Familiale. IRH trained their staff and then assisted them to conduct provider trainings. (See Table 2 below.) IRH and these partners made joint supervision visits to encourage and build skills in supportive supervision. IRH also worked with these organizations to produce and adapt provider and client tools for the sites that they support. The Twubakane Project now has the necessary capacity to independently conduct SDM training and supervision, and the Capacity Project soon will. To build capacity, IRH did not gather service statistics directly from health centers supported by Twubakane and Capacity, but agreed that partners should communicate SDM data to IRH. Thus, Table 2 does not include the number of SDM clients from these partners, as complete and representative data were not available at the time of this report. SDM activities with Action Familiale have only recently begun with a training of trainers; providers were trained in September and services began in October 2007.

In addition to capacity building in SDM training and supervision, IRH also provided technical assistance to the government and local organizations in research. Because Rwanda has been the site of several studies, IRH has worked closely with these actors on both qualitative and quantitative assessments, building knowledge and skills in areas such as mystery client visits and focus group discussions.

Table 2: Building SDM Capacity within Partners

Name of Organization	Number of Providers Trained	Number of Sites with Trained Providers	Number of Trainers Trained	Number of SDM Acceptors 2003–2007
MOH	388	69	22	5,376
ARBEF	26 + 119 CBDs	8+ 119 CBDs		646
Twubakane	110	92	3	N/A
Capacity	158	120	2	N/A
Action Familiale	0	0	14	0
Total	**800**	**408**	**41**	**6,022**

Many of the joint trainings described above were co-funded to some extent by IRH and partners. The USAID CAs also contributed to cost-sharing by paying for the reproduction of materials and purchasing CycleBeads. Initially, IRH bore the majority of the costs of activities conducted with smaller, local organizations, but has begun to work with those organizations to scale up using a cost-sharing model. Thus, ARBEF contributed funds to train providers in their remaining clinics and Action Familiale will share the cost of training their teachers to counsel couples in the SDM.

In collaboration with the PRIME-II Project, IRH worked to include the SDM in the government's in-service training manual for family planning providers. All public-sector provider trainings currently use this manual. IRH also worked with the Capacity Project to include the SDM in the recently drafted pre-service curricula, which will be tested prior to expected approval by the MOH and Ministry of Education.

D. Incorporating the SDM into reporting systems

For most of the life of the project in Rwanda (2002–2006), the SDM was partially integrated into the national reporting and MIS systems, meaning that it was included in site-level data collection procedures where SDM services were offered, but not in nationally produced tools or databases. Participating sites recorded SDM users in their registers in the "other" column and included SDM in their reports to the head of the health center. IRH collected service statistics from both government and private pilot sites, and government did not routinely collect these statistics at the central level.

In late 2006, as the viability and popularity of the SDM became clear, IRH began working more intensively with government to integrate the SDM into the national MIS. By early 2007, new family planning registers, client cards, and report templates included the SDM among other methods. These tools were distributed in September 2007 and will be used in subsequent reports to the central level. It will be important to work with the government to troubleshoot any difficulties encountered and find feasible solutions to ensure the continued integration of the SDM in national reporting systems.

E. Generating commitment of resources to SDM by governments, NGOs, or donor agencies

As mentioned in the discussion of capacity building, IRH worked closely with several organizations that made in-kind contributions to SDM activities since the beginning of the

project in Rwanda. While IRH provided technical assistance and direct support for staff time, training, supervision, and IEC activities, other CAs and local NGOs also contributed staff time, materials, and funding for training and supervision, and included the SDM in training curricula and reporting systems. In-kind contributions grew steadily over the life of the project so that, by 2007, the main CAs consistently allocated substantial resources to ensure that the SDM was fully integrated into their family planning activities. As a result of IRH's advocacy, UNFPA also provided resources for SDM scale up. Beginning in August 2007, IRH and UNFPA jointly funded trainings in the UNFPA activity zones, implemented in collaboration with other zonal partners such as Family Health International and the Adventist Development & Relief Agency. Similarly, Action Familiale agreed to cover most of the costs of integrating the SDM into its current range of natural family planning methods.

Although the government itself has not directly contributed funding to SDM activities, it has contributed significant staff time to be involved in all IRH and partner activities.

F. Incorporating SDM into the logistics system

IRH's experience integrating the SDM into the national contraceptive logistics system is similar to that of the national reporting system. Early on, the national logistics system did not include CycleBeads, as the SDM was only available at selected sites. For several years, IRH purchased and distributed CycleBeads to the participating sites. In 2006, as IntraHealth's Twubakane and Capacity Projects began including the SDM among their services, they directly purchased CycleBeads with the intent of providing them to the sites that they supported. However, IRH had been working with the government to include CycleBeads in the national logistics system. As a first step, IRH suggested that partners move their stores of CycleBeads to the central commodities warehouse, the CAMERWA. The government and partners agreed and by early 2007, the CAMERWA housed CycleBeads and provisions were made to distribute them to the regional and then district levels, where health centers could access them.

In order to further ensure sustainability, IRH worked with the DELIVER Project to include the SDM in the national contraceptive projection process. Although the central level of the health system had not routinely collected and reported data on CycleBeads' consumption, IRH provided DELIVER and the MOH with data that enabled them to estimate need for the years 2007–2009. The MOH will now include CycleBeads in the annual request for commodities that they present to USAID and UNFPA and any CycleBeads purchased will automatically be stored at the CAMERWA and follow the national distribution system. The report template that is given to health centers to indicate commodities consumption also includes CycleBeads.

G. Status of the SDM in Rwanda

IRH has been steadily working towards full integration and scale up of the SDM in Rwanda since its introduction in 2002. Recently, the project has been working with the USAID-funded Twubakane and Capacity Projects to include the SDM among the range of family planning services offered at health centers. Together, these projects cover 22 of 30 districts in the country. Much progress has been made with these two organizations, which are well on their way to having in-house training and supervision capacity. IRH also maintains and supports partnerships

with local NGOs and FBOs to further increase access to the SDM. By August 2007, the program had made the SDM available in 294 health centers and trained 22 trainers, 801 providers (including 119 CBD agents), 1,932 health mobilizers, 14 family life teachers and 8 couple counselors. Services had registered 6,085 SDM users, 95% of whom were first-time family planning users.

IRH also worked with the MOH, through relevant task forces and committees, to ensure that the SDM is integrated into national norms and systems.

Below is a list of key steps towards SDM integration in Rwanda:

- Included in 2005 DHS
- Included in the national/government family planning in-service training manual
- Included in national/government IEC materials
- Included in the recently revised national pre-service nursing curriculum
- Included in national family planning tools including register, client cards, and health center report templates
- Included in the recently revised national family planning policy
- CycleBeads included in the national logistics and distribution system

While considerable progress towards SDM integration has been made, work is still needed to ensure expanded access to the method, continued quality of services, and in-country capacity for long-term sustainability of the method. While the CAs have nearly achieved capacity for SDM training and supervision, because of their generalized reproductive health mandates and large scopes of work, they may not be able to provide the level of attention that the SDM still requires before truly achieving equal status with other more established family planning methods. Other organizations are only recently beginning SDM activities and will need guidance and technical assistance. Finally, the government has begun to incorporate the SDM into national norms, procedures, and systems but requires steady assistance to take all of the necessary steps required to achieve integration.

IV. Challenges

One of the biggest obstacles IRH has encountered in Rwanda is a persistent, if unstated, bias against natural methods among some decisionmakers, policymakers, and providers. Despite the fact that IRH has presented many times on the efficacy of the SDM and distributed evidence of its inclusion in international norms and guidelines, and despite the obvious interest in the method among Rwandan men and women, some health care professionals perceive the SDM as ineffective and, therefore, as a last choice among family planning methods. IRH has made a considerable effort to educate policymakers, present results, and conduct Rwanda-specific research in order to illustrate the potential benefits of the SDM. After four years of advocacy and research, many people now consider the SDM a desirable and appropriate addition to the method mix. However, some still remain unconvinced.

Even when providers are supportive of the SDM, health personnel are transferred to new sites fairly frequently in Rwanda. When dynamic providers leave a particular center, or when no remaining provider is trained on the SDM, such issues are difficult to address, due to lack of

control over the health center staffing. However, ensuring that more than one provider per center is trained in the SDM could potentially alleviate this problem.

The SDM is still a new method to many people; uptake is slow at the beginning and requires an accompanying promotional and IEC campaign in order to make potential users aware of an additional choice. IRH has guided the IEC activities in Rwanda up to this point with a fair amount of success. As more and more sites have begun offering the SDM, IRH can no longer feasibly coordinate comprehensive IEC activities. It would be desirable to roll SDM awareness-raising activities into the mandate of another CA working specifically on IEC. To date, comprehensive IEC activities in Rwanda have not been well coordinated and most efforts have been piecemeal.

Similarly, because the SDM is new to Rwanda, it has not previously been included in the pre- and in-service training curricula and therefore, health care practitioners are not aware of the method. Although the SDM has recently been integrated into both, it will still take some time before providers are familiar with it to the extent they are familiar with other methods. For this reason, most new SDM providers require supervision and follow up to ensure full competency and high-quality services. Again, IRH was able to provide adequate supervision when there were few sites offering the SDM. In the short term, IRH must enable partners to provide adequate supervision and, in the longer term, work to include the SDM in the government's standardized supervision tools and procedures.

As IRH has moved from directly assisting health centers to working through other organizations that support health centers, it has faced a challenge common in scale-up phases. Many of the pilot centers, accustomed to receiving direct and intensive support from IRH, still expect this level of attention from IRH's partner organizations, although the partners will be simultaneously consolidating and expanding services. It is possible that the quality of SDM services may diminish in pilot sites if partner organizations cannot provide an adequate level of support.

Finally, integrating the SDM into national family planning policies and procedures has been a slow process. IRH must work with the government and partners to coordinate integration opportunities that may arise only sporadically. For example, it has taken a number of years to integrate the SDM into the monthly service reports that health centers submit to the district and regional levels because report templates were only recently revised and reprinted. Similarly, although CycleBeads are now housed at the CAMERWA, it will take additional time to include them in tracking forms used by the distribution system to estimate contraceptive commodity needs.

V. Lessons Learned

One of the clearest lessons learned in Rwanda is that active partner engagement is critical to the success of the program. IRH has had very positive working relationships in Rwanda, which allowed for the transfer of capacity to partner organizations to sustain SDM activities. Despite positive collaboration, partner engagement is only recently extending to the commitment of funds. It is important for the Mission to encourage CAs not only to consider the SDM as part of their workplans, but also to include it in their budgets. Similarly, IRH's participation on the

Family Planning Technical Working Group was key to successfully communicating about and advocating for the SDM, coordinating activities, and leveraging resources and will be important to continue into the future.

As previously noted, IRH has also learned that dissemination of research results is critical to addressing concerns about the efficacy and feasibility of natural methods. While potential clients do not need to be "convinced" of the appropriateness of natural methods—the number of SDM users rises as it is offered in additional sites—they do need to be made aware of the availability of the SDM. Concerted IEC efforts are key to the success of the program and should include mass media as well as community-based outreach and social marketing.

IRH has also learned about the value of including religious groups, which often run or co-manage service delivery points, as partners in Rwanda. Prior to the introduction of the SDM, these religious groups (primarily Catholic) offered a very limited range of family planning methods. Through the introduction of the SDM, these organizations were able to offer an effective, simple method, thus further expanding access to family planning within the country. Partners, including the government, appreciate being able to link the health services of FBOs with the larger health service network in the country.

VI. Future plans

While IRH and partners have made much progress towards SDM integration, certain gaps remain in assuring broad access to the method, quality of services, and sustainability.

Within a short time, several in-country partners will have SDM training capacity; more time and technical assistance will be needed to ensure similar capacity for SDM supervision. The two large CAs in the country, although supportive of integrating the SDM into their programs and services, have very broad scopes of work that may preclude them from devoting the resources needed to achieve SDM integration on a level with other family planning methods. Other organizations are only recently beginning SDM activities and will need guidance and technical assistance for some time.

Including the method in CBD programs and marketing it in pharmacies and private clinics would further expand the reach of the SDM. This would require focused technical assistance for training, supervision, BCC/IEC activities, and overall systems management.

Finally, SDM integration requires ensuring that the method is a part of all national systems, from MIS, to procurement and distribution, to norms and protocols, to pre-service curricula. IRH has made great progress with the government on SDM integration into health systems. The government has begun to incorporate the SDM into the MIS by including it in revised reporting and data collection tools. CycleBeads are included in the logistics system and have been added to contraceptive projections and requests for commodities given to donors. The SDM is now included in the in-service family planning training curricula. Consolidating these significant advances will require ensuring proper collection and reporting of SDM data using revised forms, efficient distribution of CycleBeads throughout the system, verification of SDM's integration into forecasting and procurement systems, and attention to pre-service training programs.

Contacts with universities should be made, materials given, and trainings/orientations conducted so that graduating medical students of all levels are trained on the SDM.

Future work should focus on completing the process of SDM integration in collaboration with the MOH and USAID-funded projects by continuing to transfer capacity to implement and support quality SDM services and ensure sustainability at the national and decentralized levels. The above-mentioned gaps would best be addressed by an organization serving as SDM focal point in the country, able to deal directly with some issues while simultaneously guiding other organizations to respond to future needs.

There is a clear opportunity to scale up SDM services nationally through the public and private sectors. The focus should be on fully integrating the SDM into public-sector health services in two-thirds of the country through IntraHealth's Twubakane and Capacity Projects, as well as nationally with the MOH, via the various task forces and working groups in which IRH already participates. Additional assistance is needed to help UNFPA introduce the SDM into their activity zones (the approximate one-third of remaining districts), thus completing national coverage. Access could be further expanded by building SDM capacity within local NGOs and FBOs, by increasing BCC/IEC activities, and by offering the SDM via social marketing channels and CBDs.

The research on the pilot introduction of the TDM with the FBO Action Familiale Rwandaise should continue, as this is among the first operations research to be done on this method, and possibilities for expanding services after the pilot phase should be explored. Rwanda also holds potential as a site for reinvigorating Lactational Amenorrhea Method (LAM) services, given breastfeeding practices in Rwanda and the fact that it was one of the most successful sites participating in IRH's LAM efficacy study in the mid 1990s.