Promising Practices for Scale-Up:
A Prospective Case Study of Standard Days Method® Integration

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The Institute for Reproductive Health (IRH) is part of the Georgetown University Medical Center, an internationally recognized academic medical center with a three-part mission of research, teaching and patient care. IRH is a leading technical resource and learning center committed to developing and increasing the availability of effective, easy-to-use, fertility awareness-based methods (FAM) of family planning.

IRH was awarded the 5-year *Fertility Awareness-Based Methods (FAM) Project* by the United States Agency for International Development (USAID) in September 2007. This 5-year project aims to increase access and use of FAM within a broad range of service delivery programs using systems-oriented scaling up approaches.

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The analysis and preparation of this report was led by Rebecka Lundgren, Susan Igras, Nana Dagadu and Victoria Jennings. The steering committee throughout the study also included Irit Sinai, Jeannette Cachan and Elizabeth Salazar, who participated in the design and implementation of the study, analyzed data and contributed report sections. This report would not be possible without the contributions of IRH country staff Marie Mukabatsinda, Priya Jha, Karina Arriaza, Donald Moncada, Sékou Traore, and Arsène Binanga, who led scale-up technical assistance efforts in their respective countries as well as contributed to writing and analysis of country scale-up reports. Katie Cain also had significant input in drafting and editing many of the sections and prepared the original outline. Cat Toth worked closely with IRH to shape the document, providing overall editing and harmonizing the inputs of all those who contributed to the report. Danielle McCadden played an important role coordinating the writing and review process, editing report sections, integrating data and developing figures and charts to illustrate the report.

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ACRONYMS

ASHA	Accredited Social Health Activist (India)
ATN	*Assistance Technique National Plus* (bilateral health project, Mali)
CA	Cooperative Agency: an organization (often an NGO) that manages large-scale projects (often called bilateral projects) on behalf of international donors
CFU	Client Follow-Up
DHS	Demographic Health Survey
EOI3	Each One Invites Three
FAM	Fertility Awareness-Based Methods
FBO	Faith-Based Organization
FP	Family Planning
HMIS	Health Management Information System
HTSP	Healthy Timing and Spacing of Pregnancies
ICPD	International Conference on Population and Development (Cairo. 1994)
IEC	Information-Education-Communication
IPPF	International Planned Parenthood Federation
IRH	Institute for Reproductive Health
KIT	Knowledge Improvement Tool
LAPM	Long Acting and Permanent Methods
LARC	Long Acting Reversible Contraception
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare (India)
MSC	Most Significant Change
NGO	Non-Governmental Organization
PKC	*Projet Keneya Ciwara* (bilateral health project, Mali)
PSI	Population Services International
SDM	Standard Days Method
SDP	Service Delivery Point
UNFPA	United Nations Population Fund

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FOREWORD

By Richard Kohl
Center for Large Scale Social Change

In the past 50 years, despite many successful innovations, small-scale projects, and important progress, improvement in health outcomes and poverty reduction generally has been at best disappointing in too many developing countries. There is a growing recognition among development practitioners that this is due, at least in part, to the failure to scale up. Those very same innovations and projects rarely go to scale spontaneously or even with the normal efforts at knowledge dissemination, "knowledge into practice", and other variations on that theme. In recent years, especially since the 2007 worldwide recession, the need for scaling up has become even more urgent as donor and foundation budgets have been flat or declining, while in many cases the size and scope of problems are increasing. Moreover, the increasingly rapid growth rates in low and low-middle income countries in South and East Asia and Sub-Saharan Africa have meant that domestic financial resources are far less of a constraint on sustainable scale-up than they were in the past.

Over the last decade there has been a revolution in program evaluation with the increasing use of quasi-experimental and experimental evaluation designs. Improving evaluation standards have helped ensure that interventions which are candidates for scale-up meet a higher standard of impact, but it appears that better evidence alone has not proven sufficient to effect scale-up. For example, MIT's Abdul Latif Jameel Poverty Action Lab (JPAL), a world leader in applying randomized controlled trials to micro-development interventions, has evaluated the effectiveness of over 400 innovations over the last decade, but less than a handful – around one percent[i] – have gone to scale.

There has been no rigorous assessment of what percentage of promising or proven interventions have achieved any kind of scale – whether by funder, implementer, sector or country/location. The experience of this author with multiple bilateral and multilateral donor agencies and countries is that the JPAL numbers are broadly representative. In our experience, at best one in ten piloted interventions go to scale, and most frequently the one intervention that does go to scale does so in the form of a follow-up project financed and/or implemented by the same donor or a consortium of donors. In other words, even when scale has been achieved, it has often not been sustainable because of lack of successful advocacy for domestic financing and building of sustainable long-term implementation capacity.

These factors – pressures for greater scale-up, more possibilities for scale-up, and better evidence – have led to a growing appreciation that a more proactive approach to the planning, management, implementation, and monitoring of scale-up is needed if we are to increase our success rates. In response, a handful of visionary foundations and donors have supported the development of scale-up management frameworks and accompanying toolkits. Notable among them has been the establishment of global network of public health stakeholders – ExpandNet. The ExpandNet secretariat has developed a scale-up framework

[i] Personal conversations with JPAL staff, July 2013

and toolkit as part of its mission to promote equitable access to quality care by supporting the sustainable, equitable scale-up of successful health interventions along with a scale-up framework.[ii],[iii]

Therefore the following report from Georgetown University's Institute for Reproductive Health (IRH) is invaluable. This groundbreaking report for the first time moves beyond anecdotal experience to provide vital and incontrovertible evidence that a systematic approach to scale-up produces results and, thus, the investment in scale-up is worth the investment. This report summarizes the application of the ExpandNet WHO Framework to scale-up of a particular (and important) global health innovation: the Standard Days Method® (SDM) of family planning. In four of the five countries in which this was applied, scale-up with impact and sustainability was achieved. Partial success was achieved in the fifth country, the Democratic Republic of Congo (DRC), which demonstrates that even in conflict areas and fragile or failed states, scale-up is still possible, though much more challenging.

The experience that this report covers not only demonstrates the success of applying a pro-active framework to scale-up, and more importantly the field applications successfully developed and tested a number of appropriate tools for scaling up.[iv] The most important contribution of this effort is the development of a strong monitoring framework for the scale-up process itself, to ensure fidelity to the innovation and that all of the intermediate steps are being followed, such as the creation and capacity building of resources teams in each country and the Ministry of Health in particular. IRH, with the support of the ExpandNet secretariat, used a detailed monitoring approach to constantly adjust and update the scale-up strategy and an implementation plan to adjust to the ever-changing circumstances and external conditions, iterating between monitoring and implementation.

In addition to the tools and monitoring approach developed, this report illustrates many other lessons about scale-up that should widely inform practice in the field. To highlight but a few, first and foremost the process of scale-up itself takes time and resources. IRH had tested and proved the efficacy and effectiveness of SDM for several years in multiple locations and institutional settings. Yet the scale-up process itself took five years. Second, the requirements for an implementing agency to pursue scale-up are demanding. IRH was an ideal institution to fulfill this role because of its strong capacity in several areas: subject matter expertize in family planning and SDM in particular; world class technical expertise in monitoring and evaluation; ability to translate a systems perspective and approach into concrete action; sensitivity to the qualitative aspects of scaling up, including organizational and institutional cultures, incentives for

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[ii] The ExpandNet/WHO framework, as it has come to be called, was first developed in 2005-6 (and published in 2007) by a team led by Professor Ruth Simmons, at the time with the University of Michigan School of Public Health, and Peter Fajans of the World Health Organization. ExpandNet's work on scaling up grows out of the development and testing of WHO's Strategic Approach to Strengthening Reproductive Health Policies and Programmes.

[iii] The MacArthur foundation also supported the development of a scale-up management framework by Management Systems International, which has been applied internationally to multiple sectors by MSI itself and others, including the Center for Large Scale Social Change. See Cooley, L and R. Kohl. 2005 "Scaling Up—From Vision to Large-scale Change: A Management Framework for Practitioners" Washington, D.C.: Management Systems International. *www.msiworldwide.com/files/scalingup-framework.pdf* (hereafter Cooley-Kohl) and an accompanying toolkit, "MSI Scaling Up toolkit" *www.msiworldwide.com/wp.../MSI-Scaling-Up-Toolkit-FINAL1.pdf*

[iv] These include what are to our knowledge the first systematic approach to monitoring scaling up through the benchmark table and monitoring database, a key event tracking tool, staff scale up reflection guides, and graduation criteria (i.e. when a program and the implementing agency is sufficiently matured to be ready to implement on its own.)

implementers and beneficiaries; and ability to engage in boundary spanning, working across the public sector, donors, and civil society.

USAID, and the Bureau for Global Health are to be congratulated on their foresight in financing this study many years ago as its findings and insights are quite timely. As of this writing, many donor agencies are for the first time taking scale-up seriously. The UNDP, World Bank ARD, IFAD, GIZ and others are variously conducting retrospective studies of how much scale-up is occurring in their portfolios and what determines relative success, and developing tools and guidelines for their field staff so that scale-up is incorporated into the design and implementation of their projects. It can only be hoped that this report is widely read, and its valuable insights and tools are integrated into the activities of not only the Bureau for Global Health and USAID, but all funders and implementing agencies involved in global health and international development.

EXECUTIVE SUMMARY

INTRODUCTION

This summary document presents conclusions from a six-year, five-country initiative conducted by the Institute for Reproductive Health (IRH) and its many in-country partners to scale up Standard Days Method® (SDM) of family planning. SDM, briefly described in the text box at right, is itself not the topic of this document.[v] Rather, the SDM scale-up experience is the source of the contributions that IRH makes to global knowledge of the *process of scaling up* tested health service innovations.

Scale-up is *the deliberate set of efforts to increase the impact of health innovations whose merit has been established in pilot or experimental studies, to benefit more people and to foster policy and program support on a lasting basis.*[vi] This definition clarifies that scale-up does not happen spontaneously, and that if it is to be sustained, it must encompass not only expanded availability of an innovation, but also its institutionalization in policies and programs.

STANDARD DAYS METHOD® (SDM)

Based on reproductive physiology, SDM identifies a fixed set of days in each menstrual cycle when a woman should avoid unprotected intercourse if she does not wish to become pregnant. Used correctly, SDM was found to have a failure rate under 5 (per 100 women/years) among women with regular cycles of 26-32 days; with typical use, failure rate under 12. Thus, SDM efficacy is similar to other user-dependent methods. The color-coded string of CycleBeads® helps the SDM user track her cycle.

SDM helps bring new partners to family planning provision, and its scale-up offers opportunity to strengthen health systems as a whole. SDM appeals to many women who do not currently use any method, those who are concerned about side effects of other methods, and those whose belief systems preclude the use of hormonal or barrier methods. SDM helps women and men learn about their fertility, and it involves men in family planning. The method is simple to teach and use, and can be provided by clinic or community health workers. Users do not need medical exams, and they need not seek re-supply.

Learn more: http://irh.org/projects/fam_project/standard-days-method/

[v] The SDM's efficacy, acceptability, and unique contributions to meeting FP needs are documented in the following articles: *Efficacy of a new method of family planning: the Standard Days Method* (Arevalo, et al 2002), *Being strategic about contraceptive introduction: The experience of the Standard Days Method* (Gribble et al, 2008), *The role of the Standard Days Method® in modern family planning service in developing countries* (Lundgren et al, 2012), *Engaging Men in Family Planning Services Delivery: Experiences Introducing the Standard Days Method ® in Four Countries* (2012, Lundgren et al)]

[vi] Definition from WHO/ExpandNet, with minor modifications. Simmons, R. and Shiffman, J. 2007. "Scaling up health service innovations: a framework for action," in *Scaling up health service delivery: from pilot innovations to policies and programmes*, 1-30. Edited by Simmons, R., Fajans, P. and Ghiron, L. World Health Organization and ExpandNet. Geneva: WHO Press.

VERTICAL AND HORIZONTAL SCALE-UP BENCHMARKS

Sustainable scale-up of a health innovation requires efforts along two axes. Perhaps the most obvious is the expansion of services, which ExpandNet calls horizontal scale-up. Equally important, however, is the institutionalization, or vertical scale-up, of the innovation in systems and policies. The benchmarks that IRH defined and tracked against targets set for each scale-up axis, listed below, provide a clear picture of the difference between, and importance of, the two types of scale-up:

Benchmarks of expansion or horizontal scale-up:

- # and proportion of service delivery points that include SDM
- # of individuals trained to provide SDM
- # of organizations with capacity to undertake SDM activities

Benchmarks of institutionalization or vertical scale-up:

- # of key policies, norms, guidelines and protocols that include SDM
- # of institutions (public, private) that include SDM in pre-service training
- # that include SDM in in-service training
- # of donor procurement systems that include SDM/CycleBeads
- # of logistics systems that include SDM/CycleBeads
- # of HMIS/reporting systems that include SDM
- # of IEC activities/materials that include SDM
- # of national surveys that include SDM as a unique category

From 2000, when it developed SDM, through 2006, IRH conducted clinical trials, pilot introductions, operations research, and impact studies in diverse settings around the globe. IRH developed CycleBeads® (see box) and engaged with a manufacturing and distribution partner that could ensure a continuous, high-quality supply of this essential product at a cost supportable by global programs. Results of this early research suggested that SDM merited scale-up for a number of reasons (see box on page v), and the availability of CycleBeads made it potentially feasible. In 2007, with USAID support for adding a simple, modern, natural family planning method to national programs, IRH shifted its attention to planning and implementing a multi-site program of SDM at scale.

The World Health Organization's (WHO) ExpandNet framework[vii] for scale-up was selected to guide IRH's strategy to scale up SDM (see description on page four). With this framework as a guide, IRH embarked on a program that simultaneously (a) took the method to scale in five countries, thereby bringing an effective and attractive new method within reach of millions; and (b) conducted a prospective multi-site case study to document, assess, and guide the scale-up process, thereby enriching the global body of knowledge on how to expand and sustain worthy health innovations.

THE PROSPECTIVE MULTI-COUNTRY CASE STUDY

The SDM scale-up phase (2007-2013) provided a unique opportunity to carry out robust research on the *scale-up process* in the five participating countries: Democratic Republic of the Congo (DRC), Guatemala,

[vii] Simmons, R. and Shiffman, J. 2007. "Scaling up health service innovations: a framework for action." In *Scaling up health service delivery: from pilot innovations to policies and programmes*, 1-30. Edited by Simmons, R., Fajans, P. and Ghiron, L. World Health Organization and ExpandNet. Geneva: WHO Press.

India, Mali and Rwanda. IRH chose to use a prospective, explanatory case study design that featured multiple sites, various data sources (and opportunity for triangulation), and a well-documented database.

The study allowed for cross-case comparison of the five 'cases' of SDM scale-up, using quantitative and qualitative data that were systematically collected by IRH, partners and local research organizations. The data and data collection methodologies—which included baseline and endline household surveys and facility assessments, stakeholder interviews, service provision and quality audits, client satisfaction follow-up, benchmarks of horizontal and vertical scale-up (see box) and several others—corresponded to IRH's dual intentions. First, they quantified increases in access to and use of SDM as well as accomplishments in institutionalization of elements that create an enabling environment for sustainability (two of IRH's goals in the scale-up phase). Second, taken together they supported the analysis of the process and outcomes of scale-up itself.

ACHIEVEMENTS

This section presents a snapshot of selected scale-up achievements in the five participating countries and the status of SDM at the end of the scale-up phase as evidence of successes and challenges within the scale-up process itself.

SCALE-UP AIMS BY COUNTRY		
	Vertical Scale-up Aim	Horizontal Scale-up Aim
DRC	National	300 (of 515) Health Zones
Guatemala	National	3 (of 22) Departments
India (Jharkhand)	State	12 (of 24) Districts
Mali	National	Near-national
Rwanda	National	Near-national

To assist in interpretation of achievements, it is useful to note that the planned extent of scale-up varied by country. Four of the five countries chose to undertake institutionalization, or vertical scale-up, at the national level while in India, SDM was institutionalized only in Jharkhand state. As for horizontal scale-up, Rwanda and Mali had the potential to achieve near-national provision of SDM; DRC's potential was limited by poor infrastructure, a family planning program in the process of revitalization, and the spotty presence of partners on the ground. In Guatemala, IRH and partners chose to expand service delivery in three of the country's 22 Departments that were, at the time of project launch, the three focus departments for USAID support (USAID shifted focus during the project) , while in India scale-up occurred in the 50% of Jharkhand districts with the greatest need for family planning services.

PERCENTAGE OF WOMEN SURVEYED WHO WERE AWARE OF SDM		
	Baseline	Endline
DRC		37.3
Guatemala	24.6	35.2
India (Jharkhand)	2.5	49.1
Mali	28.4	
Rwanda		94.8
Source: IRH Household Surveys		

Awareness of SDM increased among women and men in all countries, but remained lower than awareness of other, more established methods (with the exception of Rwanda), an understandable situation given the relatively small resources available for SDM awareness-raising. Sources of information about SDM varied significantly by country. In DRC, more than half of respondents who had heard about the method learned

about it from a family member or a friend. In Guatemala and India, the most cited source was health facilities (46% and 67% respectively), while in Mali, most respondents (91%) learned about the method from television.

All survey respondents who had heard of SDM were asked their opinion about the method. Of the women who had heard of SDM but had never used it, 63.5% considered it effective in preventing pregnancy and 60.0% thought it would be easy to use. In contrast, these figures were 81.7% and 77% respectively for women who had ever used the SDM, whether or not they were still using the method. The percent of women using family planning who opted for SDM at endline ranged from 2.3% in Guatemala to 15.4% in DRC. Most women (97.5%) who were using the method at the time of the survey were satisfied with it, and 87.4% were planning to continue using it.

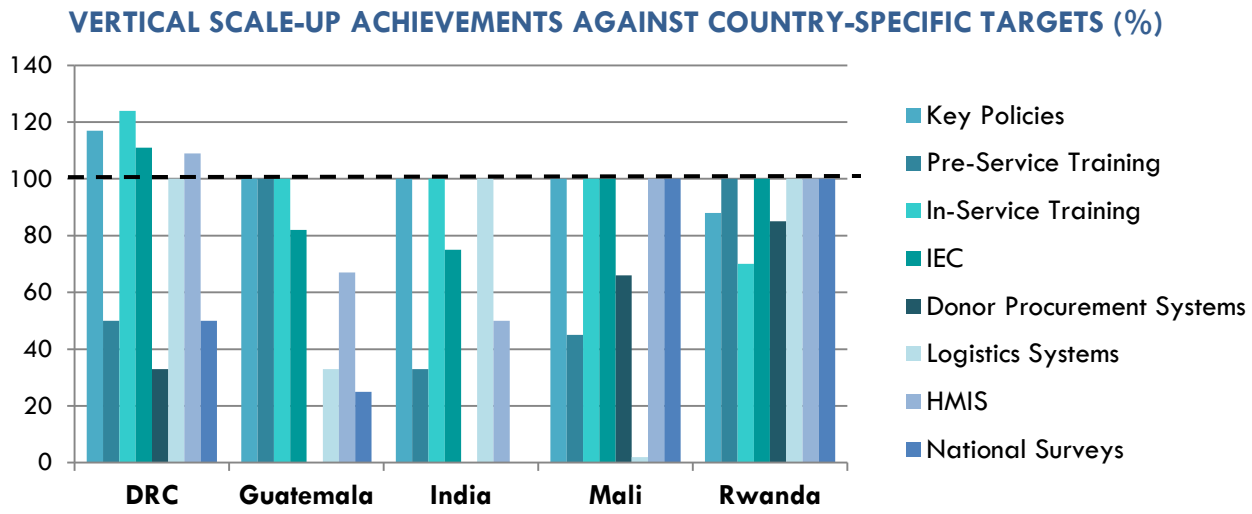
SDM USE AT BASELINE AND ENDLINE

	Ever Use of SDM (% of women)		Current SDM Use (% of women)		SDM Use (% of women using a modern method)	
	Baseline (2009; Guatemala 2010)	Endline (2012; India 2013)	Baseline (2009; Guatemala 2010)	Endline (2012; India 2013)	Baseline (2009; Guatemala 2010)	Endline (2012; India2013)
DRC	--	11.8	--	5.3	--	19.4
Guatemala	1.6	2.3	0.2	1.7	0.6	2.7
India (Jharkhand)	0.3	6.3	0.3	3.5	0.7	6.4
Mali	5.0	--	0.3	--	1.5	--
Rwanda	--	6.3	--	5.3	--	8.3

Source: IRH Household Surveys (2009-2013)

Service expansion or ***availability of SDM*** increased dramatically over the course of scale-up in all countries. At the end of the study, between 90% (in India) and 103% (in Rwanda) of the anticipated number of service delivery points were offering the SDM. The percentage of providers trained, compared to the goals set initially varies widely (DRC 54%, India 71%, Mali 89%, Guatemala 105%, and Rwanda 138%). In some cases, this is because of unrealistic initial goals, while in others; it is the result of environmental factors (e.g., political turnover, shifting donor emphasis).

Scale-up requires ***institutionalization*** of the innovation into key policies and program support systems. The figure below shows each country's achievements against its targets for vertical scale-up benchmarks.



Inclusion of SDM in norms, policies and guidelines as well as in training curricula, both in-service training and pre-service education, were early gains in vertical scale-up. Other gains took longer. For example, because national health management information systems (HMIS), procurement/delivery systems and health surveys tended to be revised every five or six years, the scale-up phase did not coincide with such events in all countries. The most difficult challenge, and one not fully resolved by the close of the scale-up phase, was to incorporate CycleBeads into some of the government and donor procurement systems and secure their financial commitment to purchase the product. Early in the project, USAID included CycleBeads in their commodities procurement system, implemented by USAID | DELIVER PROJECT, which is available to USAID missions. In countries (or areas of countries) where USAID is the donor procuring commodities, this was a pivotal decision that provided significant impetus to scale-up. In other countries/areas where other donors (primarily UNFPA) procure commodities, CycleBeads availability remained an unresolved problem.

HOW SCALE-UP WAS ACHIEVED

With WHO's *ExpandNet framework* as a guide to planning and implementing SDM scale-up, IRH and its partners considered scale-up within a system of elements that change over time, interact with and influence one another (see box). A systems approach positions scale-up as neither a wholly technical undertaking nor a managerial one, but an artful combination of the two that must respond to and influence the effects of constantly changing systems elements on one another and on the scale-up process.

IRH also adhered to ExpandNet's guiding principles for scale-up. The principles, when applied to planning and implementation, are meant to help ensure lasting benefits to those who need the innovation most. They are: *systems thinking*, a focus on *sustainability*, determining *scalability* (the suitability of the innovation for scale-up), and a respect for *human rights, gender and equity* to ensure that quality services are accessible to all.[viii] A focus on human rights during scale-up encouraged resource teams to work for SDM services provided within programs that ensure informed choice, offering good quality counseling on a range of methods. Paying attention to gender and equity issues during scale-up was integral to efforts

[viii] These principles fit well with the core values that IRH embedded in SDM itself: reproductive rights, women's empowerment, and male involvement in SDM/family planning use.

because programs integrating SDM readily recognized the importance of reaching men with family planning information and services. SDM was developed in part to reach the underserved, and resource teams prioritized efforts to reach hard-to-reach populations in several ways. For example, teams developed low-literacy materials, chose to work in areas with the greatest need, and expanded beyond facility-based services through non-clinical service delivery channels, such as private pharmacies, faith-based organizations (FBOs) and development organizations.

In each country, SDM was scaled up in partnership with the Ministry of Health and other key actors including major donors, NGOs, PVOs, community-based groups, FBOs and family planning associations. In fact, the MOH led the scale-up process in all countries, and its importance as partner and leader cannot be overstated. In addition to being the largest provider of health services and manager of family planning services in each country, the MOH provided the mandate for SDM scale-up and gave legitimacy to resource organizations to expand availability of the method. The role of IRH centered on providing guidance and technical assistance to the process. To use ExpandNet terminology, the MOH was the primary resource organization – as well as the primary user organization – in all cases while IRH served as resource organization to the resource organizations. IRH also led the monitoring and evaluation (M&E) process, ensuring that data could be used not only for documenting whether activities had occurred and goals were achieved, but also that data were used for decision-making and understanding what worked—and what didn't—during the scale-up phase.

SYSTEM ELEMENTS PER EXPANDNET:

a. **Innovation**: the SDM innovation is a package that includes the principles governing the method: CycleBeads, country-tailored counseling supports and client information aids, training curricula, and IEC materials.

b. **User organizations**: those that provide SDM to clients.

c. **Resource organizations**: those that ensure user organizations gain and maintain capacity to provide SDM (resource organizations may also be user organizations).

d. **Environment**: international and national policies on family planning, socio-cultural and religious influences, and economic factors that constrain or facilitate scale-up.

e. **Scale-up strategy**: the plans and actions needed to fully establish the innovation in policies, programs and service delivery. The strategy is the sum of a series of reasoned choices in several areas including advocacy and dissemination, costs and resource mobilization, monitoring and evaluation.

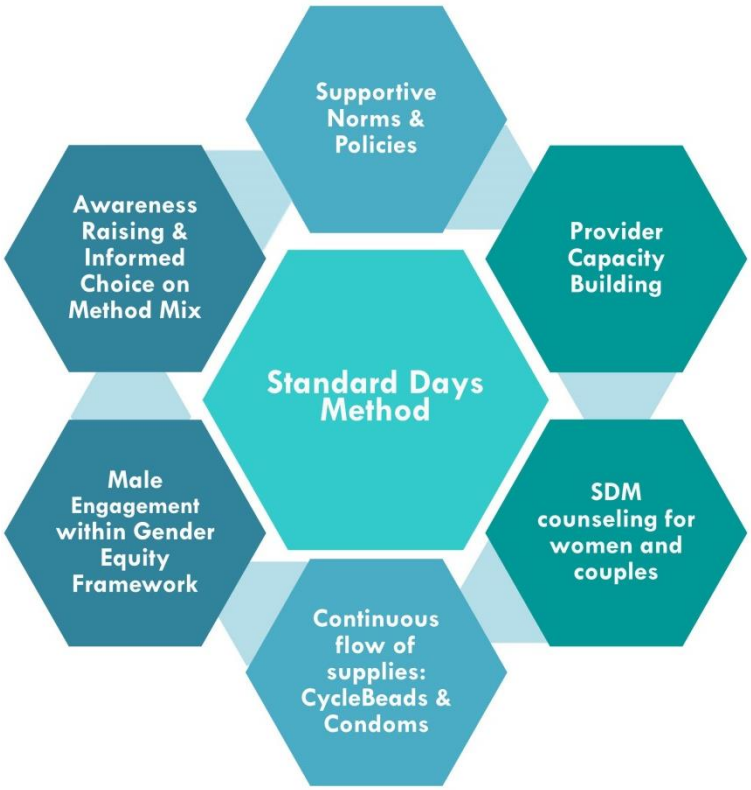
The range of technical assistance that IRH provided to the MOH and other resource and user organizations was extensive, and aimed to build *system-wide capacity* for SDM scale-up. While tailored to the needs and contexts of each country, technical assistance generally included support to training trainers and service providers in SDM (and often family planning methods as a whole), and building capacity for advocacy, supervision, IEC and logistics. Organizational and human resource capacity- building incorporated many tasks, such as integrating SDM into pre-service and in-service curricula (this often revealed the need to revise and update the larger family planning curricula for service providers and community health

workers); creating or strengthening supervision and feedback mechanisms (which were either weak or lacking entirely); and supporting effective and targeted IEC materials and activities. Early in the scale-up process, IRH directly advocated for SDM's inclusion in new donor-funded health programs and revised guidelines and materials; by the end of the scale-up phase, others were moving those advocacy efforts forward. Transferring ownership of SDM capacity-building was a key step in ensuring that capacity will be sustained over time. Finally, IRH engaged in cost and resource mobilization to further scale-up (which is a resource-intensive activity) in each country. For example, it advocated for funding, identified opportunities to leverage resources, and urged SDM's inclusion in family planning budgets.

LESSONS LEARNED ABOUT SCALE-UP

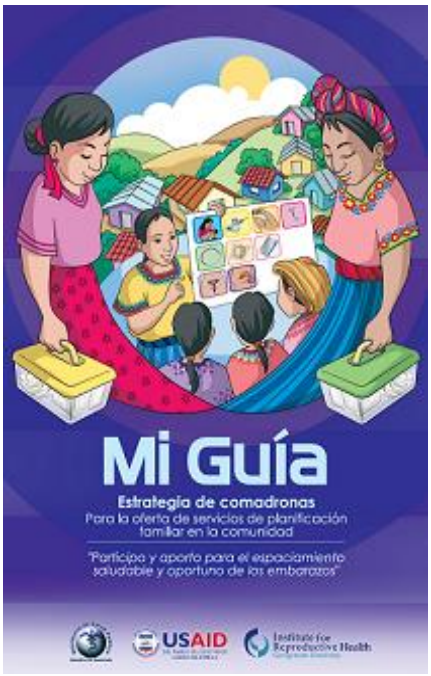
Promising Practices for Nurturing and Maintaining Scale-Up

A strong and diverse resource team: In four scale-up countries (DRC was the exception), IRH and the MOH developed a strong team made up of key resource organization representatives. The resource team was the central coordinating mechanism for systematic collaboration on scale-up. The team's composition and location in the health bureaucracy varied among countries. In Rwanda, for example, the MOH's MCH Task Force and its Family Planning Technical Working Group met quarterly to, respectively, provide primary oversight and technical input to the scale-up process; in India's Jharkhand state, meanwhile, the scale-up partners meeting was held at state level, and core committees met at district level, to oversee and coordinate the work. In Guatemala, the resource team consisted of the representatives from various MOH program and operational divisions and key stakeholders in family planning. Periodic meetings and clear roles for resource team members contributed to success. The resource team was critical not only in moving the scale-up process forward but also in ensuring local ownership and sustainability of SDM. In DRC, IRH worked closely with the central MOH; one-on-one coordination of scale up was nurtured with partners.



A designated technical leader: A designated leader was essential for providing technical assistance to the scale-up process. In each country, IRH served as `resource organization to the resource organization,' and stakeholders were near-unanimous in their agreement that this role and guidance were crucial. IRH's mandate as technical leader evolved over time. Early scale-up activities included adapting materials and curricula, training trainers and key personnel, and advocating with policy makers directly. Other resource organizations took over these tasks as their capacity grew, while IRH transitioned to quality assurance and

systems integration as scaling up progressed until its completion. In sum, IRH's main task categories as technical leader were: strategic planning for scale-up strategy, capacity building, dissemination and advocacy, resource mobilization, and monitoring and evaluation.



Simplified family planning job aid used by traditional birth attendants (TBA) in Guatemala; TBAs counseled women on the Lactational Amenorrhea Method (LAM) and provided CycleBeads, pills and condoms directly. They referred women to the health center for all other methods.

Scale-up as opportunity to strengthen health systems: In all countries, the primary user organization was the MOH (and in some cases related ministries). Governmental health systems generally needed strengthening and lacked the infrastructure, expertise and human resources to do the work of scale-up. IRH made health systems strengthening a principle of scale-up. In other words, IRH and the resource team sought opportunities to improve family planning and health service delivery as a whole while introducing and expanding access to SDM. For example, encouraging supportive supervision for SDM led to an increase in supportive supervision overall. Emphasizing the importance of quality counseling for SDM focused attention on, and ultimately improved, family planning counseling for other methods as well. Reviewing and revising in-service and pre-service family planning training curricula contributed to updating information about other methods and protocols.

Definition of the innovation: The health service innovation is at the core of any scale-up effort, but the presence of the core of the innovation alone—in this case SDM and the accompanying CycleBeads tool—is insufficient for successful scale-up. Instead, a package must be defined and developed to support the innovation, and include items (such as user instructions, training modules, provider counseling aids, outreach materials, and supervision tools) and activities (such as quality assurance monitoring, awareness-raising, tracking adherence to principles, and oversight). IRH and stakeholders in each country began to define the SDM innovation in the earliest days of the intervention, and indeed this exercise facilitated strategic planning for scale-up as a whole: the participatory process of defining the innovation helped stakeholders grasp the systemic and multi-actor nature of scale-up.

Simplification of the innovation: Invariably, elements of the innovation package had to be simplified to meet the needs of the implementing systems. As work progressed, resource teams ensured that revisions in the innovation package over time continued to produce comparable results to the pilot studies. In all countries, the service provider training was shortened for integration into contraceptive technology updates, and simplified job aids and low-literacy training approaches were developed to meet the needs of cadres of providers new to offering SDM (such as development and community health workers, see figure). User instructions were translated into several new languages—five in DRC alone—and text reduced in favor of more illustrations for ease of use by low-literacy clients. Simplified or modified materials and

activities were tested to ascertain that service quality and correct use were not compromised by the changes.

Demand creation integral to scaling up: Demand creation is an integral component of scaling up any innovation within an existing service delivery system. It encompasses the array of efforts made and media used to raise awareness and create interest among potential users and those who influence them. Before becoming interested in using a method or supporting its use, people must be aware that the method—in this case SDM—exists and know at least some of its attributes. Strategies can be designed to diffuse not only new information, but also to change attitudes and behaviors. In other words, demand creation can help solidify the 'social reputation' of an innovation. IRH found that the transition from introducing SDM to scaling up SDM required shifts in demand creation strategies, including targets, audience segmentation, and approaches. The scale-up phase required much broader target audiences (not only larger number of people to be reached and audience segmenting, but also a need to reach those who could influence demand creation efforts). Thus it was critical to engage a number of partners. For example, Population Services International (PSI) has the mandate and the capacity to produce and air radio and television spots. In Mali, where SDM was included in PSI's television campaign to promote their line of contraceptive products, 81% of women who had heard of SDM reported television as their source of information. Mass media campaigns were often implemented concurrently with community-level activities such as street theater and peer health talks. Efforts to diffuse information through social networks were remarkably effective. In another example, the *Each One Invites Three* strategy, adapted from the SanteNet Project's work in Madagascar, provided satisfied family planning users—women and men—an "invitation card" to reach out to non-user friends. This strategy, implemented through community health workers and associations in Rwanda, yielded a 39% increase in new family planning users compared to the six months prior to the campaign, while a slight decrease was observed in the control area. Demand creation for scale-up requires significant resources, and it is unclear whether efforts to raise awareness of SDM will continue beyond inclusion in already-printed materials such as MOH posters and pamphlets.

Champions of SDM: Individual champions were mentored in each country, and used their own time, resources and professional connections to advocate for greater access to and sustainability of the innovation. Each such contribution, even when small, helped advance scale-up; many champions achieved gains that IRH could not. For example, champions reached organizations that IRH did not target, and their advocacy approaches (with service providers, program managers, MOH officials) were based on strong personal relationships. IRH recognized and benefitted from the championship of *Conduite de la Fécondité*, a Rwandan FBO that invited and encouraged other FBOs to integrate and promote SDM in their work. *Mamans An'sar***,** a Muslim FBO in DRC, also persuaded religious leaders to accept and advocate for SDM, and to refer couples and women to family planning services. FHI360 representatives in Kenya also championed SDM inclusion as service and other guidelines were being revised by the MOH. The long-term effects of these spontaneous cases of SDM championship are uncertain, as they require on-going technical support.

Importance of leveraging M&E information—such as family planning service statistics and the results of national and regional surveys—to support the process of scale-up. Timely sharing of data kept stakeholders engaged in the scale-up process, and allowed for evidence-informed mid-course corrections. For example, IRH staff in Jharkhand collected district- and block-level statistics monthly, analyzed and

graphed them, then met with district program managers and medical officers to identify and address problems in training, stock outs, record keeping, and service quality. Integrating innovations into health management information systems is a critical component of scale-up, and the resource teams worked tirelessly to ensure that SDM was included in MOH reporting forms and that data on SDM users was rolled up to the central level. These efforts were successful in DRC, Mali, Rwanda and Guatemala, where SDM is now included in the HMIS at all levels. However, sustainability in DRC, where the HMIS is in its infancy in Mali, where unrest resulted in ending scale-up activities before this could be accomplished, and in India, where the centralized nature of the HMIS limits ability to include SDM in the one state in which it was scaled up, is uncertain. For similar reasons, integrating SDM into national surveys was challenging, and efforts were successful only in Rwanda and potentially DRC (survey planned for 2014.) Secondary data from studies conducted for purposes other than SDM scale-up were used to identify gaps in the extent and quality of SDM services and community knowledge of SDM. In Rwanda, for example, when benchmark indicators showed good progress, but a government facility survey suggested a serious problem in supply chain mechanisms leading to facility level stock-outs, the resource team took action to resolve the problem. Overall, M&E supports expansion by: (1) assessing adaptation of the innovation package; (2) guiding strategic planning; (3) identifying and monitoring resolution of problems; (4) maintaining stakeholder commitment to the scale-up process; and (5) involving new partners in scale-up.

Donors influence scale-up in expected and unexpected ways

The scale-up countries' family planning programs (other than India) rely on donor support, including most or all procurement of contraceptive supplies and funding for large-scale health projects. Major donors thus had tremendous influence on SDM scale-up.

As noted earlier, **USAID**, which provided funding to IRH for the scale-up phase, included CycleBeads in the global procurement mechanisms through the USAID | DELIVER PROJECT. This was a tipping point for scale-up success and sustainability in the three African countries where USAID is the primary organization procuring commodities. USAID's technical priorities, however, had contradictory effects on scale-up. On one hand, USAID promoted a) healthy timing and spacing of pregnancies and b) community-based family planning approaches, both of which support expansion of SDM services. On the other hand, the priority that USAID increasingly placed on (c) permanent methods and long-acting and reversible contraceptives outweighed the areas in which it supported SDM, particularly in Rwanda, Guatemala and India.

IRH's use of **WHO**'s ExpandNet Framework as a guide to scale-up and technical assistance by ExpandNet experts for scale-up and planning legitimized SDM scale-up in the eyes of many MOH officials and others. Also, WHO included SDM in its 'four cornerstones' of family planning publications and published an "advisory note" on CycleBeads procurement, lending further legitimacy to the method and its scale-up. However, WHO does not include CycleBeads in its essential medicines list (CycleBeads is not a medicine, but other contraceptives are), and this was **UNFPA**'s stated reason for declining to procure CycleBeads for the programs it supported in the five scale-up countries. This had a debilitating effect in Guatemala and, to a lesser extent, in DRC where UNFPA procures commodities for several regions.

USAID mission personnel also affected SDM scale-up. Turnover sometimes resulted in a need for IRH and its partners to expend considerable time and effort educating and advocating with new personnel – often people who were new to USAID and had little experience in family planning – and, in some countries, a shift

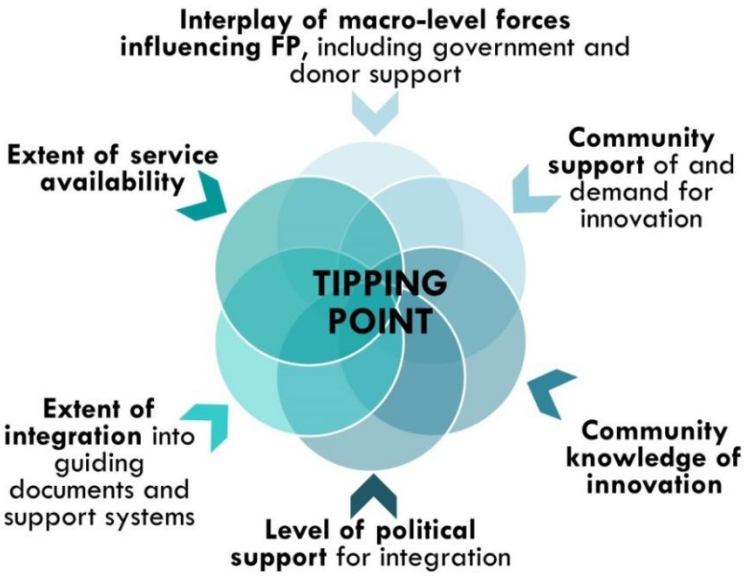
from a supportive mission to a very challenging one. Consistent support in some missions, on the other hand, greatly contributed to scale-up success.

Partners influence scale-up in expected and unexpected ways

SDM scale-up occurred via partnerships, from the first participatory planning meetings through the end of the scale-up phase in early 2013. IRH's primary partner in each country was the MOH, often its reproductive health division. Other major stakeholders included donors, NGOs and other agencies that implemented large-scale health projects such as FBOs, training institutions and private-sector service providers, from social marketers to family planning associations. Partners influenced scale-up in many ways.

Consistent government, particularly MOH, support aided scale-up, but high turnover among officials required near-continuous advocacy on behalf of SDM in Guatemala and India. Where political support for family planning as a national development strategy was strong, as was especially the case in Rwanda, scale-up was vastly facilitated, though the MOH's focus there on long-acting methods diverted attention from SDM. Several of the tipping points necessary for sustainable scale-up (see box) relied on MOH influence: these included the level of political support for SDM integration and extent of SDM integration into guidance documents and family planning sub-systems (e.g., logistics, HMIS).

Reaching the tipping point for sustainable scale depended on a web of linked factors within each country, and on several global factors (see figure).



Donors' **bilateral health programs**, implemented by NGOs or other technical assistance agencies, were positive forces that greatly facilitated horizontal scale-up of SDM in African countries but not in India or Guatemala. A willing bilateral partner had the wherewithal to expand SDM services with quality and at scale. In Mali, for example, the USAID-funded *Projet Keneya Ciwara* facilitated SDM's introduction in seven of Mali's eight regions and parts of its capital city. IRH's contributions of technical assistance were multiplied many times over by the project's large staff and implementation zones. Bilaterals also had their own funding, and often contributed human or other resources to scale-up activities. Relying on bilaterals had drawbacks, however: they never covered an entire country, were by nature temporary (making sustainability uncertain), and IRH was one step removed from direct oversight of scale-up tasks, limiting quality assurance efforts. Some, such as those in India and Guatemala, perceived their mandate as incompatible with including SDM in their programming, thus limiting possibilities for scale-up. In Rwanda, the USAID bilateral project closed during the second year of the scale-up phase, and another project did not begin for over two years, creating a

hiatus in the potential to integrate SDM into bilateral programming. To overcome gaps where bilateral partners were negative or not present, IRH worked directly with MOH services and with non-bilateral partners including UNFPA, NGOs and FBOs.

Providing technical assistance to scale-up requires a particular skill set and perspective among staff

The shift from researching and introducing an innovation to scaling it up requires a change of perspective among staff, as well as new skills. Using the ExpandNet framework to understand, plan for and carry out SDM scale-up was a valuable tool for IRH staff who, in earlier points along the research-to-practice continuum, had not necessarily focused on actions required for sustainability. It fostered a mindset of 'passing the baton' and the need to create capacity rather than "be" the capacity for training, advocacy, procurement, supervision, etc. Moreover, the framework made clear that scale-up included, but was more than, geographical expansion: it sharpened focus on the need for and elements of institutionalization of SDM. As IRH's role evolved, so did its staff's skill sets. While staff initially saw themselves as the trainers, experts, and advocates, they were able to shift their emphasis to being mentors and colleagues, supporting others in both technical and political areas.

SDM at scale makes unique contributions to family planning programs

SDM's unique characteristics as a family planning method created new and important opportunities during the scale-up phase. Because SDM is a fertility awareness-based method, FBOs, often on the periphery of or excluded entirely from national family planning programs, were active and valuable contributors to scale-up, especially in the three African countries. Because SDM is most effective when practiced by couples (and not by women only), scale-up activities, especially but not limited to awareness-raising and demand-creation, invited men's participation in family planning and reproductive health activities. On the other hand, bias against SDM as a "natural" method was a limiting factor. Significant effort had to be expended persuading stakeholders of its value, and IRH had to consistently "prove" that its intent was to incorporate SDM in the method mix, not to replace other methods, as was supposed by some. These are but three of several examples, but they exemplify the importance of carefully taking into account the characteristics of the innovation to be scaled when planning and conducting scale up.

The ExpandNet framework and its systems approach were valuable at all stages of scale-up, and led to wide availability of quality, sustainable SDM services

Scale-up is a complex process that involves many actors and interrelated factors. The systems-oriented ExpandNet framework broke the process into components that could be more easily understood and acted upon. It provided a conceptual roadmap for planning, monitoring progress, and guiding decision-making, and offered a common visual tool and vocabulary. IRH, both centrally and in the countries in which SDM was being scaled up, used the framework to plan a multi-year scale-up strategy. Thereafter, IRH and its resource teams in Guatemala and Mali continued to use ExpandNet to engage and involve partners. In other countries, the framework became an internal planning tool although the systems approach it espoused was a continuous feature of work with partners.

The table below summarizes the many ways that IRH and its partners made use of the ExpandNet framework.

A systems approach, as articulated by ExpandNet, ensured that IRH, its partners, and other stakeholders grasped the importance and meaning of both horizontal and vertical scale-up, and accounted for the many tasks required to achieve them. It helped the five resource teams understand how best to plan and manage concurrent work along the horizontal and vertical axes.

SCALE-UP FUNCTION	FRAMEWORK UTILITY
PLANNING	▪ Foster shared vision ▪ Road map/planning tool ▪ Facilitate understanding of scale-up requirements ▪ Identify barriers and opportunities ▪ Identify relations between systems
ADVOCACY & PARTNER/ STAKEHOLDER ENGAGEMENT	▪ Identify potential partner roles ▪ Develop work plans involving multiple partners ▪ Identify areas for advocacy
MANAGING SCALE-UP PROCESS	▪ Provide common scale-up language ▪ Inform realignment of staff roles for scale-up ▪ Identify areas for staff development ▪ Teach systems thinking ▪ Maintain focus on activities that promote sustainability ▪ Prioritize activities ▪ Maintain focus on guiding principles
MONITORING & EVALUATION	▪ Develop indicators/benchmarks ▪ Annual review tool ▪ Framework for organizing analysis/reports ▪ Assess changing environment and systems

The systems-oriented approach also helped actors track and maximize the positive effects (or minimize the negative effects) of the many environmental, institutional, political and policy forces, both international and national, that influenced their work. This approach prompted IRH and stakeholders to consider points of view of influential actors not typically associated with health services delivery. After learning to apply the ExpandNet framework, for example, the resource team in Guatemala developed a strategic plan to advocate with stakeholders outside of the health system (e.g. faith-based organizations and women's rights groups) to prepare for the potential negative effects of a change in government on SDM integration, in particular inclusion of CycleBeads in the contraceptive procurement tables. In Rwanda, environmental scans indicated a need to increase political support for SDM scale-up and reduce bias within influential physician networks. IRH, therefore, published articles in the local WHO bulletin to reach physicians with evidence and information that positioned SDM as an effective, long-use method that complements long-acting methods. In Mali, work with civil society groups including religious leaders and women's groups was undertaken to influence social acceptability and demand for SDM (and family planning) and provide a forum for grass-roots advocacy for an SDM option.

The ExpandNet framework helped IRH staff make the mental shift required when moving from the SDM introductory phase to scale-up. Prior to adoption of the framework, IRH staff sought opportunities to spread SDM availability in all five countries, but did not necessarily focus on actions needed for sustainability. The framework provided a comprehensive picture of the work required to achieve both: it

sharpened the focus on the need for, and elements of, institutionalization of the innovation, alongside the more evident need for geographic expansion.

Adherence to guiding principles and core values facilitated scale-up

The ExpandNet framework's guiding principles, and the core values that IRH embedded into SDM itself, proved more than theoretical. Rather, they advanced the scale-up process. For example, a focus on gender and reproductive rights supported service quality monitoring (of counseling and informed choice), involved men in and increased couple communication about family planning overall, and helped strengthen client-centered, multi-method programs. Making equity a priority meant that IRH and partners reached underserved populations. In India, for example, the choice was to work in districts with the greatest needs for family planning services; in all countries, materials and messages were adapted to serve low-literacy clients. Moreover, the principle of equity drove the expansion of SDM provision beyond facilities: SDM scale-up included non-clinical service delivery channels including community health workers, FBO-managed family life and couples counseling services, private pharmacies and retail outlets, and non-health organizations.

Embracing systems approaches means giving up control of the scale-up process

During pilot studies and early introduction of an innovation, the researchers and/or implementation organizations generally have significant control over how the innovation is offered. Training providers, developing and distributing client materials and job aids, measuring progress, and managing the project are resource-intensive activities that are performed during pilots and early introduction by those who have a particular interest in the outcome. During scale-up, on the other hand, these functions have to be transferred to others, or scale-up is not sustainable. The advocacy, mentoring, and "letting go" necessary for sustainable scale-up require a shift in focus and different skills. Another requirement is the patience and persistence to constantly monitor what is happening in the environment that affects scale-up of the innovation and the ability to address those issues that inhibit scale-up.

Systems are not static: gains can be reversed and monitoring is needed

Frequent turnover in personnel due to political changes has been cited previously as a challenge for scale-up. Given the importance of high-level stakeholders in supporting scale-up as well as the innovation being taken to scale, significant resources are required to bring new stakeholders on board. In Rwanda, for example, a change in personnel resulted in SDM, which had been part of the Performance Based Financing scheme to reward high-performing facilities, was eliminated as a performance indicator. Advocacy efforts had failed to re-institute SDM in this financing approach by the end of the scale-up phase. In Guatemala, a revision of the family planning norms, which previously had stated the accurate SDM failure rate, would have included a higher rate—that of periodic abstinence—if a vigilant stakeholder from the MOH had not called it to IRH's attention and offered an opportunity for (successful) advocacy.

Balancing need for horizontal results with need to sustain vertical results

Because IRH's goal was to both expand access to and use of services and to make them sustainable, efforts focused on both horizontal and vertical results. The time and financial resources required to reach vertical goals delayed investments in demand creation in all countries. In Guatemala, initial resistance to SDM by key stakeholders absorbed the attention of the resource team to focus initially on institutionalization. In

DRC, horizontal achievements could only be achieved in new health zones as donor health sector rehabilitation projects were funded, leading to a cross-patch effect on expansion. During several years of low resources availability to support expansion, IRH focused scale-up efforts on institutionalization in DRC.

CONCLUSION

Scale-up is a messy, frustrating business! It requires three elements: time, resources, and a mind-set that says, "we aren't the do-ers, we help the do-ers do". Without these three elements, scale-up efforts, which are often embodied in time-limited, donor-funded projects, will be truncated before success is achieved. Insufficient resources will not allow horizontal spread, systems change, or champion development, and those who are leading the scale-up effort will continue to function as expert resources beyond the time when expertise should reside in others. Scale-up is both an art and a science. Early wins are often challenged by shifting priorities and personnel. A focus on expanding access and use of an innovation can dilute efforts to incorporate the innovation in systems, but an emphasis on including it in systems at the expense of expansion can result in negative perceptions of the innovation's potential impact. Ultimately, approaching scale-up systematically, using monitoring and evaluation to guide decisions, and focusing on the transfer of capacity and responsibility from resource to user organizations can result in successful — and lasting — scale-up.

INTRODUCTION

Promising Practices for Scale-up: A Prospective Case Study of Standard Days Method Integration describes processes and results of the Institute for Reproductive Health (IRH) at Georgetown University's scale-up of the Standard Days Method® (SDM) of family planning (FP) over five years in five countries.

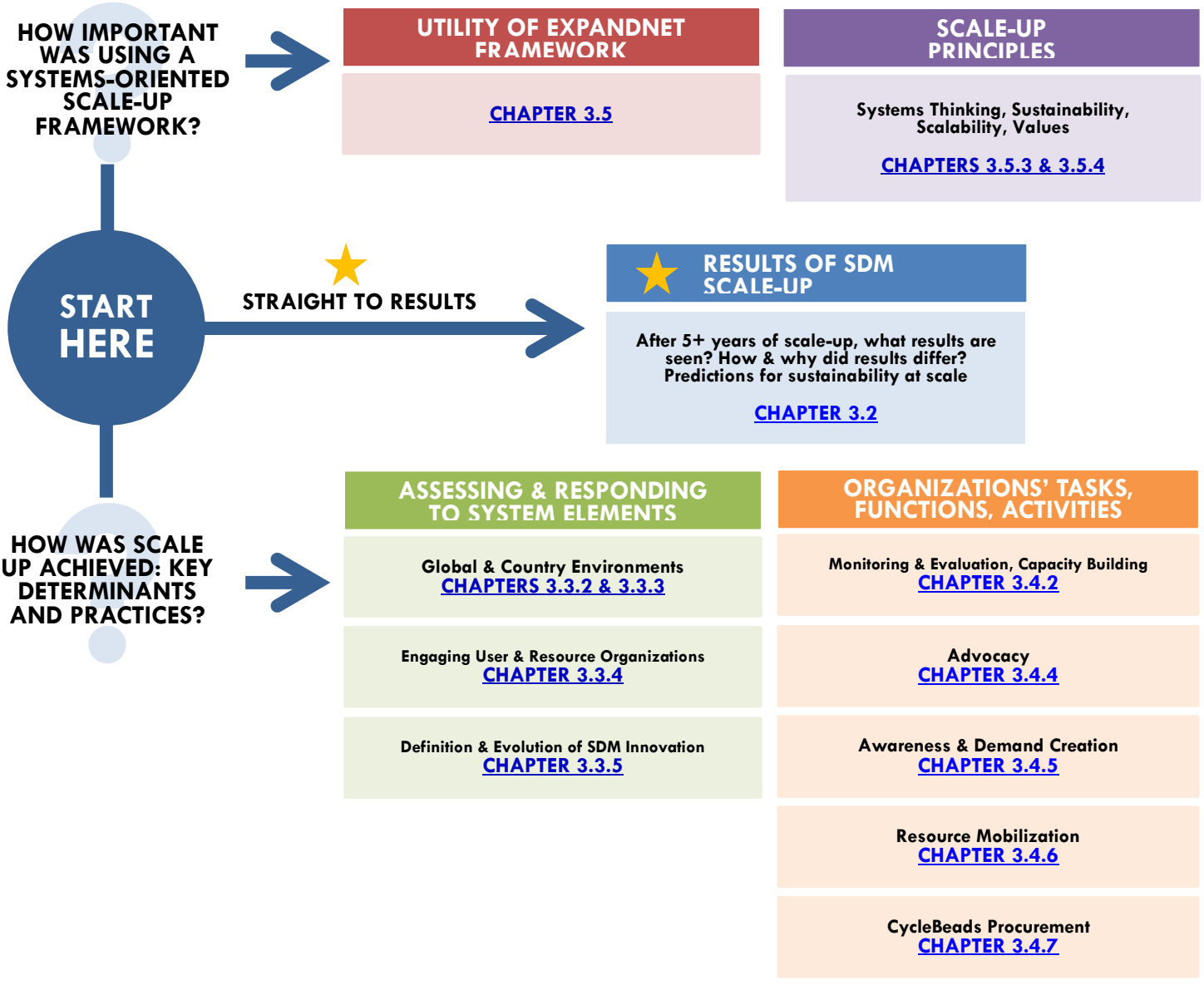
Chapter 1 provides background to the case study: despite evident demand, most FP programs around the globe did not offer an effective, fertility awareness-based method (FAM). While such methods existed, they were perceived as ineffective and cumbersome to integrate into existing FP programs. IRH developed the SDM in 2000, then tested its effectiveness and acceptability via operations research in 12 diverse settings on three continents over four years. IRH found that women and couples could use SDM effectively and with satisfaction; moreover, SDM was simple and streamlined enough that it could be integrated into clinic settings and into community health worker programs. This phase was followed by introduction studies in three countries from 2004 to 2007 which tested SDM integration at larger scale (e.g. district, sub-region). The results of these studies refined services delivery strategies for implementation at larger scale and showed that adding SDM into programs did not decrease use of other modern methods and contributed to increased contraceptive prevalence rates.

IRH then turned to a second research phase to determine how the proven SDM could be sustainably taken to scale in existing public and private health service systems. From 2007 to early 2013, IRH used the World Health Organization's (WHO) ExpandNet Framework, described in Chapter 1.3, to guide sustainable scale-up of SDM in the Democratic Republic of Congo (DRC), Guatemala, India, Mali, and Rwanda. IRH designed the five-year scale-up research as a prospective, explanatory case study (whose objectives and methodology are treated in Chapter 2), the outcomes of which would form a strong contribution to the limited global body of research on the sustainable scale-up of health innovations.

Chapter 3 presents information on the results of SDM scale-up. Chapter 3.2 offers topline data on achievements in geographic expansion of SDM, method institutionalization in health systems, political and cultural support for the method, and knowledge of, demand for, and use of SDM. The ensuing sub-chapters turn from *what* was achieved, to *how* it was achieved: the alliances that IRH formed globally and within each scale-up country, and those alliances' strategies (3.3), actions and tasks (3.4), are discussed. Challenges, both national and global, and how IRH and partners did or did not overcome them, also feature in these chapters. Chapter 3.5 reflects on the usefulness of the ExpandNet framework and its guiding principles to the scale-up process, and their contribution to scale-up results.

Promising Practices for Scale-up: A Prospective Case Study of Standard Days Method Integration concludes in Chapter 4 with reflections on the hypothesis that was tested in the case study, laid out at the onset of the SDM scale-up phase, about following a systems-oriented approach to scale-up. Use Figure 1 below to navigate the report.

Figure 1: Roadmap to the Case Study



CHAPTER 1: BACKGROUND

1.1 Problem Statement and Rationale

The international FP movement is considered by many to have begun in 1952, when the International Planned Parenthood Federation (IPPF) and Rockefeller's Population Council were founded, and when the government of India launched the world's first national FP program.[1]

The ensuing half-century saw tremendous financial outlays for FP programs and important advances in contraceptive technologies. Yet in the first decade of the new millennium, the modern contraception needs of an estimated 15% of all women aged 15 to 49 (concentrated in Sub-Saharan Africa and South Central Asia) remained unmet.[2] Estimates from 2012 put this number at 222 million women worldwide.[3] The challenge remains to reach more women with contraceptive options that appeal to them.

A major milestone in the FP movement was the 1994 International Conference on Population and Development (ICPD) in Cairo. There, the global FP community affirmed that reproductive health and rights, women's empowerment, and gender equality should be central concerns within population and development programs and policies.[4]

While FP programs had for years promoted a range of options that included hormonal, barrier, reversible and surgical methods, one category was missing from most programs: effective, scientifically-tested methods based upon users'

STANDARD DAYS METHOD® (SDM)

Based on reproductive physiology, SDM identifies a fixed set of days in each menstrual cycle when a woman should avoid unprotected intercourse if she does not wish to become pregnant. Used correctly, SDM was found to have a failure rate under 5 (per 100 women/years) among women with regular cycles of 26-32 days; with typical use, failure rate under 12. Thus, SDM efficacy is similar to other user-dependent methods. The color-coded string of CycleBeads® helps the SDM user track her cycle.

SDM helps bring new partners to FP provision, and its scale-up offers opportunity to strengthen health systems as a whole. SDM appeals to many women who do not currently use any method, those who are concerned about side effects of other methods, and those whose belief systems preclude the use of hormonal or barrier methods. SDM helps women and men learn about their fertility, and it involves men in FP. The method is simple to teach and use, and can be provided by clinic or community health workers. Users do not need medical exams, and they need not seek re-supply.

Learn more: http://irh.org/projects/fam_project/standard-days-method/

[1] Robinson, W. and Ross, J.A. (editors) 2007. "The global family planning revolution." *World Bank*, Washington, DC. http://siteresources.worldbank.org/INTPRH/Resources/ GlobalFamilyPlanningRevolution.pdf. Accessed 29 July 2012.
[2] Singh, S., Darroch, J., Ashford, L., and Vlasoff, M. 2009. "Adding it up: The costs and benefits of investing in family planning and Maternal and Newborn Health." *Guttmacher Institute and United Nations Population Fund*, New York, NY. http://www.guttmacher.org/pubs/AddingItUp2009.pdf Accessed 29 July 2012
[3] Ibid.
[4] United Nations Family Planning Association. "Report of the International Conference on Population and Development: Cairo 5-13 September 1994."1995. *United Nations*, New York. ISBN 92-1-151289-1 http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd_eng.pdf

fertility awareness. It was not that highly effective fertility awareness-based methods (FAM) did not exist. The SymptoThermal method and the Billings Ovulation Method, for example, had been demonstrated in the scientific literature to have effectiveness rates that rivaled many of the more widely-promoted contraceptives[5, 6].

Rather, three problems accompanied these FAMs. There were persistent misperceptions that they were ineffective,[7, 8] and appropriate only for those whose religious beliefs precluded the use of other methods. FAMs were also perceived to be more complex than other options and required significant time to teach and learn: it was difficult to integrate them into typical FP services due to their time-intensive counseling process[9]. Despite attempts to streamline FAMs and their service delivery protocols, misperceptions and feasibility issues persisted. Put simply, these effective FAMs could not be scaled up to reach the millions of women who needed them. IRH learned this firsthand in its early work, supported by USAID, to expand access to natural methods through public and non-profit sector FP programs.

1.2 Addressing the Problem: The Standard Days Method

It was in the wake of the ICPD that a group of researchers at IRH developed a new method that could potentially meet more women's needs for FP and address the service issues related to offering FAM. IRH's new method was a simple, effective FAM, feasible to integrate into FP programs, called the Standard Days Method® or SDM. For use by women whose menstrual cycles are between 26 and 32 days long, SDM specifies a fixed window of fertility from days 8 through 19 of the cycle.[10] A multi-country study established the failure rate of SDM as 5 with correct use and 12 with typical use, similar to that of other user-directed methods.[11]

SDM's unique features make it a strong complement to the typical basket of FP choices. Commonly used with a visual tool called CycleBeads® to track the menstrual cycle, it is a knowledge-based method that does not require restocks or repeat visits to medical providers. It is a user-directed method that involves men, enables women to learn more about their bodies, and empowers women and couples with information they can use to plan their families and their lives. Importantly, it is a method that puts women in control of their fertility and takes gender into account: incorporating SDM into FP programs aligns with ICPD's recommendations to promote reproductive rights.[12]

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[5] Frank-Herrmann, P., et al. 1997. "Natural family planning with and without barrier method use in the fertile phase: efficacy in relation to sexual behavior: a German prospective long-term study." *Advances in Contraception:* (13) 179-189.
[6] Bhargava, H., Bhatia, J.C., Ramachandran, L., Rohatgi, P., and Sinha, A.. 1996. "Field trial of Billings ovulation method of natural family planning." *Contraception:* 53(2) 69–74.
[7] Arévalo, M. 1997. "Expanding the availability and improving delivery of natural family planning services and fertility awareness education: Providers' perspectives." *Advances in Contraception:* 13(2/3) 275-281.
[8] Stanford J., Thurman P., and Lemaire J. 1999. "Physicians' knowledge and practices regarding natural family planning." *Obstetrics & Gynecology*: (94) 672–678.
[9] Arévalo, M. (1997). Expanding the availability and improving delivery of natural family planning services and fertility awareness education: Providers' perspectives. *Advances in Contraception*, 13(2/3), 275-281.
[10] Arévalo, M., Sinai, I., and Jennings, V. 2000. "A Fixed Formula to Define the Fertile Window of the Menstrual Cycle as the Basis of a Simple Method of Natural Family Planning." *Contraception* 60(6): 357-360.
[11] Arévalo, M., Jennings, V, and Sinai, I. 2002. "Efficacy of a new method of family planning: the Standard Days Method." *Contraception* 65: 333-338.
[12] Gribble, J.N. 2003. "The Standard Days Method of Family Planning: A Response to Cairo." *International Family Planning Perspectives* 29(4): 188-191.

The high number of users of periodic abstinence around the world[13] led IRH researchers and USAID colleagues to believe that a method like SDM would appeal to many women, and results from IRH's operations research studies from 2002 to 2005 showed that to be the case. The studies, which took place in 12 diverse settings in India, Africa, and Latin America, demonstrated that women could use SDM correctly and with a high degree of satisfaction.[14] These and subsequent operations research studies conducted from 2005 to 2007[15, 16] showed that women chose SDM in significant numbers and that it was feasible to integrate SDM into standard, ongoing FP programs.

SDM was shown to have certain relative advantages over existing FP method options. While it was not appropriate for all women, it met the needs of many who desired a non-hormonal method or a method that would let them involve their partner and/or learn about their fertility. In fact, the most common reason women gave for choosing SDM was that it was natural and had no side effects[17]. Another advantage was that, unlike some other FP methods, SDM could be offered successfully by community health workers: research showed that a woman need not visit a medical provider for access. Further, providers found the method easy to teach, and women found it easy to learn and to use[18]. With these positive findings, it was clear that SDM had the potential to address unmet need for FP if it were *scaled up*—that is, if it were made widely available as a FP option.

In 2007, IRH, with USAID support, launched a five-year initiative to scale-up SDM in five countries.[19] The initiative was designed as a prospective, comparative research study of the process and outcomes of scaling up. The purpose of the research was to document and understand how a FP innovation—specifically, SDM—could be incorporated into mainstream FP programs and achieve sustainability. Lessons learned could be applied to similar SDM scale-up efforts in more countries, and could inform the expansion of other evidence-based reproductive health innovations. (Note that, while the scale-up process and research described in this document occurred in five countries, recognition of SDM has continued to grow: by the end of 2012, SDM was incorporated into the national FP norms and policies of at least 16 countries.)

The five-year initiative was commonly referred to as the **SDM scale-up phase** to differentiate it from the preceding introductory phase with its operations research and introduction studies. This work was funded by USAID and formally known as the **FAM Project** (2007-2012). The countries that IRH and USAID selected

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[13] Che, Y. et al. estimate that 27 million couples worldwide, 21 million of whom live in less-developed regions, were using some form of periodic abstinence as of 2000. However, "the proportion of users with correct knowledge of the timing of ovulation ranges from 8% to 91%, with a median value of 62%". Thus, many of these users do not have correct knowledge of the fertile window and therefore are not protected against pregnancy.

[14] Gribble, J., Lundgren, R., Velasquez, C., and Anastasi, E. 2008. "Being strategic about contraceptive introduction: the experience of the Standard Days Method." *Contraception; 77*(3): 147-154.

[15] Lundgren, R., Naik, S., Johri, L., Sood, B., Jennings, V. 2007. "Expanding contraceptive prevalence in India through fertility awareness based methods of family planning." Obs. & Gynae. Today: 12(9): 426-430.

[16] Blair, C., Sinai, I., Mukabtsinda, M., Muramutsa, F.. 2007. "Introducing the Standard Days Method: Expanding family planning options in Rwanda." African Journal of Reproductive Health: 11(2):60-68.

[17] Gribble, J.N. 2003. "The Standard Days Method of family planning: A response to Cairo." International Family Planning Perspectives: 29(4):188-191.

[18] Blair, C., Sinai, I., Mukabtsinda, M., Muramutsa, F. 2007. "Introducing the Standard Days Method: Expanding family planning options in Rwanda." African Journal of Reproductive Health: 11(2):60-68.

[19] In India, IRH also brought the Lactational Amenorrhea Method to scale.

for scale-up were Guatemala, India (Jharkhand state), Madagascar, Mali and Rwanda. Madagascar experienced a *coup d'état* in 2008; IRH ceased activities there and DRC was chosen as the fifth scale-up country.

1.3 The Science and Art of Scale-up: Theoretical Background

With the onset of the FAM Project in 2007, IRH made a crucial shift, turning away from operations research and toward scale-up. With this shift, IRH moved from examining what happened when SDM was integrated into FP programs to determining how SDM could be expanded to achieve maximum benefit, taking into consideration key principles such as human rights and equity of access.

At that time, however, the scientific literature on the *process of scaling up* a health innovation was sparse. It was clear that innovations successfully implemented in pilot projects rarely reached their full potential at scale; there were few 'success stories' that IRH could use as models.

After reviewing such scale-up guidance as existed, IRH chose the World Health Organization's **ExpandNet framework** and tools to guide SDM scale-up. The ExpandNet framework is based upon a review of literature from the fields of FP, health and development, the diffusion of innovations and research utilization, and management and policy sciences. It provides a theoretical base for the scale-up process and step-by-step information on how to develop a scale-up strategy. ExpandNet is also a network of practitioners, and offers lessons drawn from members' first-hand experience in scale-up in Asia, Africa, and Latin America.[20]

A Systems-Thinking Approach to Scale-Up

Scaling up is portrayed as an open system of five elements that interact with one another: the innovation, the user organization, the environment, the resource team or organization and the scale strategy…An open-systems perspective means that the task of scaling up is not exclusively a technical and managerial undertaking, unaffected by the outside world. It is heavily influenced by environmental factors [and] critical choices have to be made about the type of scaling up, dissemination and advocacy, the organization of the scaling-up process, costs and resource mobilization as well as monitoring and evaluation.

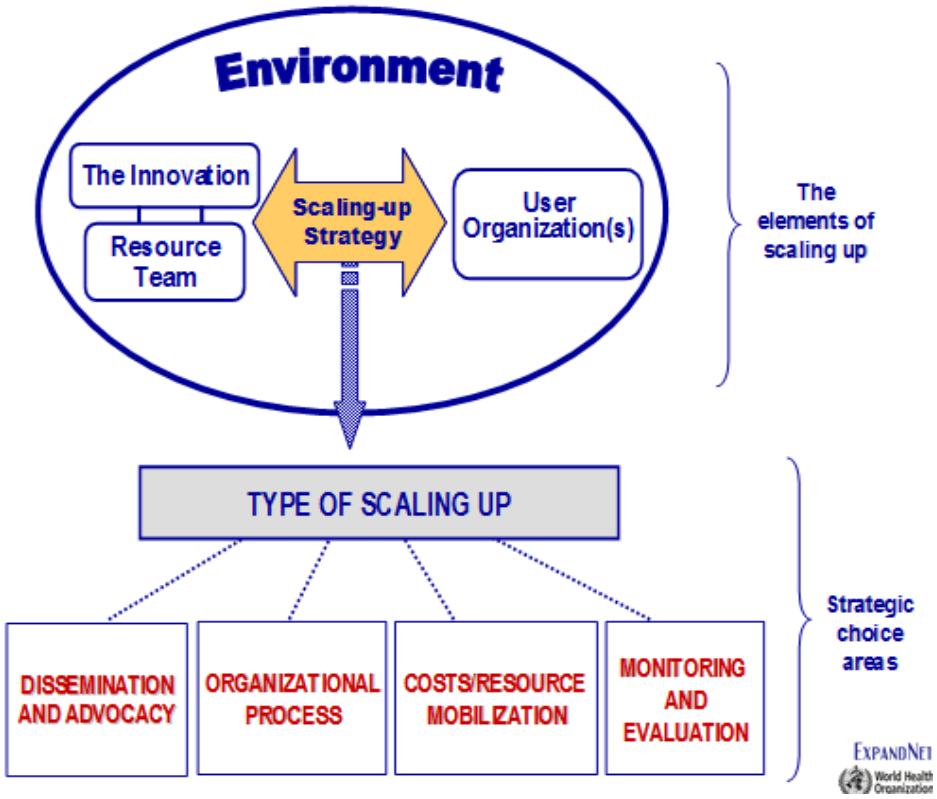
Practical guidance for scaling up health service innovations, page 7, WHO/ExpandNet

The developers of the ExpandNet framework defined scaling up as '*deliberate efforts to increase the impact of health service innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and program development on a lasting basis.*'[21] Inherent in this definition are two important concepts. First, scale-up rarely happens spontaneously: deliberate, planned, strategic action must be taken to achieve it. Second, scale-up requires institutionalizing the innovation so it is sustainable and remains in place indefinitely.

[20] Simmons, R. and Shiffman, J. 2007. "Scaling up health service innovations: a framework for action," in *Scaling up health service delivery: from pilot innovations to policies and programmes*, 1-30. Edited by Simmons, R., Fajans, P. and Ghiron, L. World Health Organization and ExpandNet. Geneva: WHO Press.
[21] Ibid.

The ExpandNet framework offered IRH a way to conceptualize scale-up, and vocabulary to describe it. The framework components are categorized as *elements* (see upper portion of Figure 2) including a scale-up strategy, which itself is the sum of reasoned choices made in a number of *strategic choice areas* (lower portion of Figure 2). The elements and strategic choice areas are briefly defined below:

Figure 2: ExpandNet Framework



Elements of scale-up:

- *The Innovation*: The health service intervention that is being scaled up. The innovation often consists of several components, such as a FP method or device plus the educational and other tools that are used with it.
- *Resource Team*: The individuals and organization(s) who promote and facilitate wider use of the innovation and who educate others on how to deliver the innovation.
- *User Organizations*: The institution(s) or organization(s) that seek to or are expected to adopt and implement the innovation. These may include ministries of health (MOH), non-governmental organizations (NGOs), and private provider networks.
- *Environment:* The conditions and institutions that are external to the user organization(s) but affect the scale-up process. These may include governmental policies, politics, bureaucracy, socioeconomic conditions, and cultural factors.

- *Scaling up strategy:* The plans and actions necessary to fully establish the innovation in policies, programs, and service delivery. The scale-up strategy is, in effect, the sum of a series of reasoned, strategic choices in several areas, as delineated below.

Strategic choice areas:

- *Type of scale-up:* The two main types of scale-up are: *vertical*, which entails integrating the innovation into policies and institutions; and *horizontal*, which means geographically expanding the reach of the innovation. The strategic choices that appear below must be made for each type of scale-up, and the resource team must decide how much attention to give to each scale-up type, and when.
- *Dissemination and advocacy:* Scaling up an innovation requires a variety of interpersonal and impersonal dissemination and advocacy strategies (in-person meetings, policy briefs, publications and more) that build awareness and support for the innovation at multiple levels.
- *Organizational process:* This rather broad strategic choice area may include decisions about the pace and scope of scale-up; the number of organizations involved; and whether scale-up is participatory or donor/expert driven, central or decentralized, and adaptive or fixed.
- *Costs/resource mobilization:* Scale-up requires resources above and beyond typical service delivery. Resource mobilization refers to identifying and securing funds or in-kind contributions for scale-up activities, and may also refer to ensuring that budgetary allocations are in place to pay for the innovation for years to come.
- *Monitoring and evaluation:* M&E assesses the process, outcome, and impact of scale-up activities, and provides data with which to make adjustments, maximize impact, and determine when scale-up is achieved. A resource team may choose to collect and use a variety of data, such as service statistics, special studies, local assessments, and environmental analyses.

The ExpandNet framework also includes four *guiding principles* that, when applied to scale-up planning and implementation, help ensure lasting benefits to those who need the innovation most. The guiding principles are: *systems thinking*, a focus on *sustainability*, determining *scalability* (the suitability of the innovation for scale-up), and a *respect for human rights, equity and gender perspectives* to ensure that quality services are accessible to all. The first three principles are briefly discussed here; Chapter 3.5 contains reflections on applying the four principles to scale-up and their influence on outcomes.

In line with the guiding principles of *systems thinking* (text box pg. 20) and a *focus on sustainability*, IRH considered how scale-up of SDM in a given country could also contribute to strengthening that country's health system. Scaling up a health innovation intrinsically requires efforts to strengthen health systems so that the innovation is accessible, affordable, and sustainable. IRH referred to WHO's Framework for Health Systems Strengthening[22] as it planned the scale-up strategy.

[22] World Health Organization. 2007. *Everybody business: strengthening health systems to improve health outcomes: WHO's framework for action.* WHO Press: Geneva. http://www.who.int/healthsystems/strategy/everybodys_business.pdf Accessed 10 August 2013.

Table 1: How Scale-up Can Contribute to Health Systems Strengthening

WHO Health System Building Block	Examples of how SDM scale-up could strengthen each building block
Leadership and governance	• Fostering multi-organizational collaboration • Implementing evidence-based approaches • Using scale-up monitoring and evaluation data for decision-making
Improving capacity of health workforce	• Reevaluating issues such as task sharing and supportive supervision • Integrating SDM into in-service and pre-service training
Service delivery	• Improving counseling skills by learning to screen clients and teach SDM • Expanding FP access through community-level service delivery • Bringing more attention to FP programs as a whole and how quality can be improved for all methods
FP product availability	• Learning how to forecast demand and procure CycleBeads appropriately • Managing introduction of new methods into distribution systems and bridging the gap between district warehouses and health centers
Health information systems	• Sharing system-wide data, such as MOH FP services statistics, to monitor scale-up allowed stakeholders to view FP (not only SDM) program issues more generally and identify solutions

IRH thus designed scale-up not only to reach more people with quality SDM services, but to strengthen health systems, and FP programs in particular, so they could sustain high-quality SDM and other service delivery. Because systems thinking recognizes that a health system exists within a larger environment and set of influences, IRH scale-up considered a wide range of stakeholders, the influence of global trends and inputs, and the possibility of singular events (political shifts, new national and international initiatives) that affected the scale-up process.

The principle of *scalability* deals with assessing an innovation's attributes to determine if it is suitable for scale-up. A scalable innovation is one that: is credible and evidence-based; is relevant to the population; has relative advantages over existing practices; is easy to install and understand; is compatible with existing values, norms, and facilities; and is testable.[23] Importantly, SDM met all these criteria. Its evidence base derived from extensive operations research in most of the countries that chose to scale-up SDM. In other words, country-specific research had already clarified that the method worked, that it met the needs of the population, that it was compatible with existing values, norms and facilities, and that it was testable.

1.4 Purpose of the Prospective Case Study

Without scale-up, the full potential of a promising reproductive health innovation such as SDM cannot be realized. But to understand what influences scale-up, information on processes and outcomes must be systematically collected. By 2007, to IRH's knowledge, no multi-site, prospective study on scale-up had ever been done. IRH, therefore, designed *scale-up research* to dovetail with the five-year scale-up phase. Its prospective, explanatory case study incorporated multiple sources of evidence collected in the five countries from November 2007, when the FAM Project began, through early 2013. Using a multi-case

[23] As cited in ExpandNet's Nine Step Guide. Glaser E., Abelson H., and Garrison, K. 1983. *Putting knowledge to use: facilitating the diffusion of knowledge and the implementation of planned change*. San Francisco: Jossey-Bass Inc. As cited in ExpandNet's Nine steps for developing a scaling up strategy.

design, the study compared the five 'cases' of SDM scale-up, drawing upon both quantitative and qualitative data collected by IRH and local research organizations.

The goal of the scale-up phase was to increase access to and use of SDM in five countries; therefore, the overall purpose of the case study research was t*o describe the process and outcomes of SDM scale-up using the ExpandNet framework and identify key factors that influenced SDM scale-up*.

CHAPTER 2: THE PROSPECTIVE CASE STUDY

2.1 Hypotheses and Objectives

To manage the case study process, and to guide data collection and analysis, IRH developed a hypothesis, objectives, and research questions. The hypothesis was:

> *Applying a systems framework and scale-up principles (as articulated in the ExpandNet framework) will lead to wide availability of quality, sustainable SDM services…where technical assistance activities facilitating the scale-up process include advocacy, building leadership, capacity building in systems analysis, transferring skills and ownership; and application of scale-up principles includes a participatory systems approach, making strategic choices based on evidence, attention to quality, and sustainability considerations.*

The complementary (null) hypothesis was: applying a systems framework and scale-up principles (per the ExpandNet framework) will not lead to wide availability of quality, sustainable SDM services.

The case study's five specific objectives are presented below. See Appendix A for the research questions related to each objective.

Table 2: Case Study Objectives

Specific Objectives	
1	To compare and contrast similarities and differences in the innovation and the process and outcomes of SDM scale-up across countries.
2	To assess the usefulness of applying the ExpandNet framework (a systems approach) to scale-up.
3	To identify promising practices and key determinants of scale-up (facilitating and constraining factors), using ExpandNet as an organizing framework.
4	To describe the unique contributions of SDM scale-up to reproductive health at the organizational and individual level.
5	To identify the facilitating and constraining factors specific to SDM scale-up.

2.2 Methodology

2.2.1 Overview

To fully understand how the complex scale-up process occurs, novel research methods are needed. To date, the literature on scale-up of innovations has focused primarily on the attributes of an innovation, patterns of innovation/technology adoption, and the use of opinion leaders. Much less has been written on the process of scale-up itself.[24]

The dearth of literature on the scale-up process may be due, in part, to the considerable challenges inherent in this type of research, including the complex interpretive process underlying adoption, pervasive pro-

[24] Simmons, R., Fajans, P., and Ghiron, R. 2007. Scaling up health service delivery from pilot innovations to policies and programmes. World Health Organization, ExpandNet: Switzerland.

innovation bias on the part of researchers, and the need to incorporate laborious mixed-method studies to gather information on both process and impact. In addition, scale-up research needs to be theory driven and requires a focus on systems rather on individual behavior.

IRH chose the explanatory case study methodology to assess scale-up of SDM across the five countries. More than a data collection method, the case study methodology answered questions of 'why' and 'how.'[25] The case study method was appropriate for studying scale-up of an innovation such as SDM because the research goal was to understand a complex process. By combining quantitative and qualitative data from multiple sources including household surveys, facility assessments, quality assessments, and in-depth interviews, the study was able to provide a comprehensive picture and analysis of the scale-up process.

2.2.2 Use of the ExpandNet Framework

The grounding of SDM scale-up research in the ExpandNet framework provided a starting point for IRH to develop the case study methodology and define research questions; ultimately, it also guided data analysis and significantly defined IRH's work in the scale-up phase. In fact, beyond influencing research design, the ExpandNet framework guided the project's theory of change and facilitated operationalization of the scale-up concept. See Appendix B for the relational framework of SDM integration, which is based on the tenets of the ExpandNet framework and Appendix C for the project's in-country and global logic models, which derive from the relational framework.

2.2.3 Methods

IRH and partners collected a variety of quantitative and qualitative information to answer the research questions that guided the explanatory case study. Multiple data sources increased the rigor of the case study by allowing triangulation of results from different sources. The data collection methods are listed in Table 3, and defined in the subsequent text. The methods are discussed again in Chapter 3.4.2 (Monitoring and Evaluation), as the information they yielded was also used to track the scale-up process in the five countries and to inform scale-up planning.

The **household survey** provided quantitative information about awareness, knowledge, and use of SDM and other FP methods by women and men of reproductive age at baseline and endline.[26] IRH developed a structured questionnaire based largely on the contraceptive section of the Demographic and Health Surveys (DHS), with an additional in-depth module that captured SDM awareness, current use, and ever use, while controlling for demographic characteristics. Overall contraceptive prevalence and shifts in the use of various methods were compared from baseline to endline.

Service statistics were routinely collected from health facilities, and included the number of new users of all FP methods, including SDM, by method. These allowed IRH and partners to monitor the spread and uptake of SDM services in the scale-up areas, and compare these to other FP services. Depending on the country, statistics were collected monthly or quarterly; they were analyzed to determine trends and identify where additional technical assistance or scale-up support was required.

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[25] Yin, R.K. 1990. *Case Study Research: Design and Methods*. Newbury Park: Sage Publications.

[26] Household Surveys were conducted at the following times in the five countries: DRC: Endline, 2012; Guatemala: Baseline 2010, Endline 2012; India: Baseline 2009, Endline 2013; Mali: Baseline, 2009; Rwanda: Endline 2012.

Table 3: Methods

Type of Indicator	Method	Type of Data	Frequency
Outcomes: • Awareness and use of SDM • Availability of quality services • Provider competency	Household Survey	*Quantitative*	*Twice – baseline & endline*
	Service statistics	*Quantitative*	*Ongoing*
	Most Significant Change (MSC) Story Collection	*Qualitative*	*Once (Year 4)*
	Knowledge Improvement Tool (KIT) and Client Follow Up (CFU)	*Quantitative*	*Semi-annually*
Outputs: • Providers trained • Clinics offering SDM • Demand-oriented Information, Education and Communication (IEC) • Supportive partners/ stakeholders • Systems integration	Facility / Service Delivery Point (SDP) Survey	*Quantitative*	*Twice – baseline or midline & endline*
	Stakeholder Interviews	*Qualitative*	*Twice – baseline & endline*
	Benchmark Reporting	*Quantitative*	*Semi-annually*
Process: • Scale-up strategy • Types of scale-up • Dissemination and advocacy • Capacity building • Organizational process • Resource mobilization • Environmental influences	Focus Group Discussions with IRH headquarters and field staff	*Qualitative*	*Three times*
	Key events timeline	*Qualitative*	*Ongoing*

The **Most Significant Change** (MSC) technique[27] is an inductive, indicator-free, participatory evaluation method that complements deductive methods. MSC involved gathering stories from those most immediately involved (e.g. FP clients, clinic staff, FP program managers), around predefined 'domains of change.' Three domains were defined for MSC collection: changes in the lives of SDM users; changes noted by service providers since SDM introduction; and changes detected by program managers since SDM was integrated into their programs. By allowing respondents to describe phenomena that they valued, MSC uncovered scale-up effects not detected by quantitative evaluation data, and intangible aspects of SDM scale-up such as advocacy, champions, leadership, gender equity and informed choice, among others.

Provider competency was assessed using an IRH checklist called the **Knowledge Improvement Tool** (KIT). The KIT was used at a sample of facilities with providers who had been trained in SDM, or directly with community health workers, and measured their understanding of SDM counseling. The **Client Follow**

[27] Dart, J. and Davis, R. 2003. "A Diagonal, Story-Based Evaluation Tool: The Most Significant Change Technique". *American Journal of Evaluation* 24(2): 137-155.

Up Tool (CFU), a brief survey, was administered periodically in conjunction with the KIT to ensure that clients were using SDM correctly and with satisfaction. Data were used to verify that the innovation components remained effective as they were scaled up, and to identify where additional supervision was needed.

Service Delivery Point (SDP) surveys assessed the status of SDM integration and quality of services at the facility level. They were conducted at baseline (or midline) and endline and had two components. First, the facility assessment was a visual review for SDM-related commodities and IEC materials; a short interview with the facility manager to gauge whether SDM services were offered; and SDM's inclusion in record keeping and information systems. Second, interviews with facility-based providers and community health workers assessed level of training in SDM, correct understanding of SDM, competency and experience in offering SDM, and attitude (including biases) toward SDM in relation to other FP methods.

Stakeholder interviews were held with key individuals in governments and MOHs, NGOs, faith-based organizations (FBOs), professional associations, educational and training institutions, donor organizations, cooperative agencies (CAs) and other entities involved in SDM scale-up. Interviews touched upon inclusion of SDM in organizational norms and guidelines, IEC, supervision, information systems, commodity distribution systems, staffing, and resource allocation. Interviews also covered the pace and quality of scale-up including facilitating and constraining factors, and questions about the larger environment (political, socio-cultural) in which scale-up took place.

Benchmark reporting was done semi-annually, using benchmarks that IRH and partners selected at the start of the scale-up phase. Benchmarks for the horizontal (expansion) and vertical (institutionalization) types of scale-up were measurable and easy to operationalize, and each was attached to *targets*, or realistic projections of what was expected to be achieved in each country annually and by the end of the scale-up phase. The benchmarks were:

Table 4: Benchmarks of SDM Scale-up

Horizontal scale-up	• Proportion of SDPs that include SDM as part of the method mix • Estimated number of individuals trained (with IRH support) to counsel clients in SDM • Number of organizations with capacity to undertake SDM activities (are resource organizations)
Vertical scale-up	• Number of key policies, norms, guidelines, and protocols that include SDM • Number of public and private training organizations that include SDM in pre-service training • Number of public and private training organizations that include SDM in in-service training • Number of donor procurement systems that include SDM/CycleBeads • Number of logistic systems that include SDM/CycleBeads • Number of HMIS/reporting systems that include SDM • Number of IEC activities, materials, and mass media efforts that include SDM • Number of national surveys (not IRH initiated) that include SDM

IRH created a database in Microsoft Access® to record benchmark data against targets. Twice annually the data were aggregated into tables, where the current figures were compared to the benchmark targets

established at the beginning of the scale-up phase. In each country and globally, IRH reviewed the semi-annual reporting tables, with an eye toward evaluating progress, identifying problems, and determining possible mid-stream adjustments as needed. Data review over the course of the scale-up phase allowed for a comprehensive assessment of the SDM scale-up process across the five countries.

IRH Washington staff periodically held **focus group discussions (FGD) with country-based staff** to assess their perception of scale-up progress, understand what led to achieving (or not achieving) project milestones, and examine how the ExpandNet framework was used in planning and implementation. This information was used to better understand and document the scale-up process.

Finally, a **key event timeline** in each country recorded internal and external events that positively or negatively influenced the scale-up process. Events were listed by country staff as they occurred, and twice yearly were entered into a specially designed Excel® spreadsheet that plotted them on a timeline. Events were not analyzed independently, but were viewed in conjunction with, and to assist in interpretation of, all other scale-up data. The timeline offered a high-level view over time, and provided information that was not captured in other case study tools. These included:

- Advances in horizontal scale-up, such as major training events held by IRH or partners.
- Accomplishments in vertical scale-up, such as integration of SDM into a nursing pre-service curriculum, or inclusion in the DHS.
- Coordination of the scale-up process, such as annual partner or resource team meetings, important discussions with the MOH or donors.
- Political events, such as a change in MOH leadership.
- Natural or other crises, such as a government declaration of famine or *coup d'état.*
- Publications of research that included SDM findings.

CHAPTER 3: RESULTS OF SDM SCALE-UP

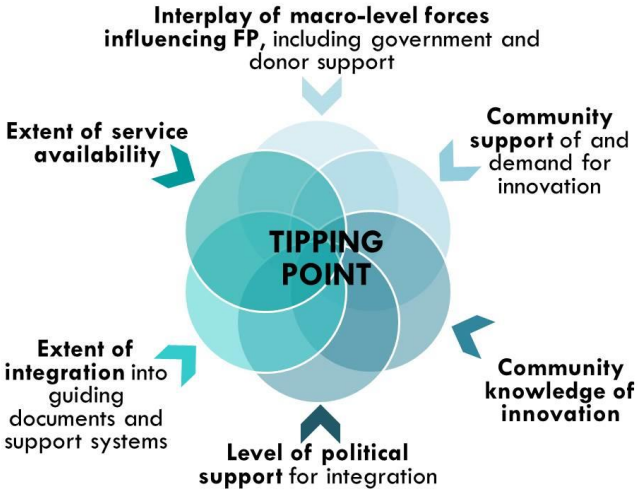
3.1 Overview

This chapter presents the results of SDM scale-up at the close of the FAM Project in early 2013. Section 3.2 offers data to demonstrate *what was achieved* in horizontal and vertical scale-up, in political support, awareness of and demand for the method, and level of SDM use at the end of the five-year scale-up phase. It concludes with an analysis of SDM sustainability in each of the five scale-up countries. Section 3.3 turns to *how* these results were achieved, by analyzing the system elements spelled out in the ExpandNet framework (Figure 2): the SDM innovation, the global and national environments in which scale-up occurred, and the resource and user organizations instrumental in SDM scale-up. Section 3.4 continues the theme of *how* results were achieved, with discussions of the many tasks, functions, and activities that comprised the scale-up process within and across the five countries. Section 3.5 reflects on the usefulness of the ExpandNet framework to the scale-up process and outcomes, and discusses how IRH and partners applied the framework's four guiding principles, and with what results.

3.2 What Was Achieved? The Status of SDM Scale-up after Five Years

Without systematic and concurrent work toward horizontal (service availability) and vertical (institutionalization) scale-up, the sustainability of SDM offered at scale cannot be achieved. The data presented in Sections 3.21, 3.2.2, and 3.2.3 reflect the constellation of horizontal and vertical factors and environmental forces that, if aligned, should lead to a sustainability tipping point (Figure 3). In Section 3.2.4, these findings are considered in relation to IRH-determined thresholds of the different factors, to allow for prediction of which countries appear to be best positioned to achieve sustainable and widespread SDM services going forward.

Figure 3: Tipping Point



3.2.1 Extent of SDM Services Availability: Horizontal Scale-Up

Each of the five scale-up countries had a unique starting point, and thus defined its SDM scale-up goals differently. Table 5 shows selected country goals and achievements related to service availability.

Table 5: Country-specific scale-up goals and SDM services availability (selected indicators)

Country	Scale-up Phase Goal*	Achievements (date)	% of Goal Achieved
DRC	SDM available in 762 SDPs in 300 of DRC's 515 health zones	SDM available in 749 SDPs (June 2012)	98.3%
	1,140 providers trained to offer SDM	615 providers trained (June 2012)	53.9%
Guatemala	SDM available in all 308 SDPs in 3 departments (about 1/6th of country)	SDM available in 305 SDPs (December 2012)	99.0%
	1,809 providers trained to offer SDM	1,973 providers trained (December 2012)	109.1%
India	SDM available at 2,100 SDPs in 12 of the 24 districts in Jharkhand State	SDM available in 1,900 SDPs (June 2013)	90.5%
	15,000 providers trained to offer SDM	11,796 providers trained (June 2013)	78.6%
Mali	SDM available in 1,320 (90%) of SDPs nationwide	SDM available in 1,273 SDPs (March 2012)	96.4%
	7,000 providers trained to offer SDM	6,208 providers trained (March 2012)	88.7%
Rwanda	SDM available in 690 (95%) of SDPs nationwide	SDM available in 717 SDPs (July 2012)	103.9%
	5,400 providers trained to offer SDM	7,472 providers trained (July 2012)	138.4%

*Source: IRH M&E reports *Goal statements were simplified for this table*

Mali and Rwanda, the two countries that planned and achieved near-national scale-up, came close to the ultimate scale-up goal: that SDM become a routine part of public-sector FP service delivery. Their challenge will be to ensure that these gains are maintained over time.

In post-conflict DRC, IRH's scale-up goal was to accompany the MOH as it revitalized FP services, in phases, across the country: IRH pegged its scale-up goal to the 300 health zones that the MOH planned to revitalize in its 2007-2012 strategic plan. At the close of the FAM Project, 99% of service delivery points were offering SDM. From the perspective of health zone coverage, 283 of 300 health zones, or 94%, were offering SDM as part of FP services. The MOH has since revised its targets and expects to achieve full FP coverage in all 515 health zones by 2017. Viewed from this perspective, by the end of the scale-up phase, SDM was being offered in 55% of all 515 health zones, and the remaining scale-up challenge in the DRC will be to ensure that SDM remains an element of the MOH's FP program revitalization even when revitalization is supported by other donor projects.

Guatemala and India had more limited goals for SDM availability, and SDM as part of routine service delivery nationwide was not fully assured. Guatemala scaled up in three departments, or about one-sixth of the country, and India in 12 of 24 districts in Jharkhand State, which is one of 28 states in the country. In contrast to Mali and Rwanda, Guatemala and India were in the early stages of national scale-up by the close of the scale-up phase. They built partial foundations, and produced evidence of feasibility and effect of including SDM, that could lead to expanded policy and political support to extend SDM into FP services nationwide at a future date.

Strategies used and challenges encountered while expanding SDM services availability.

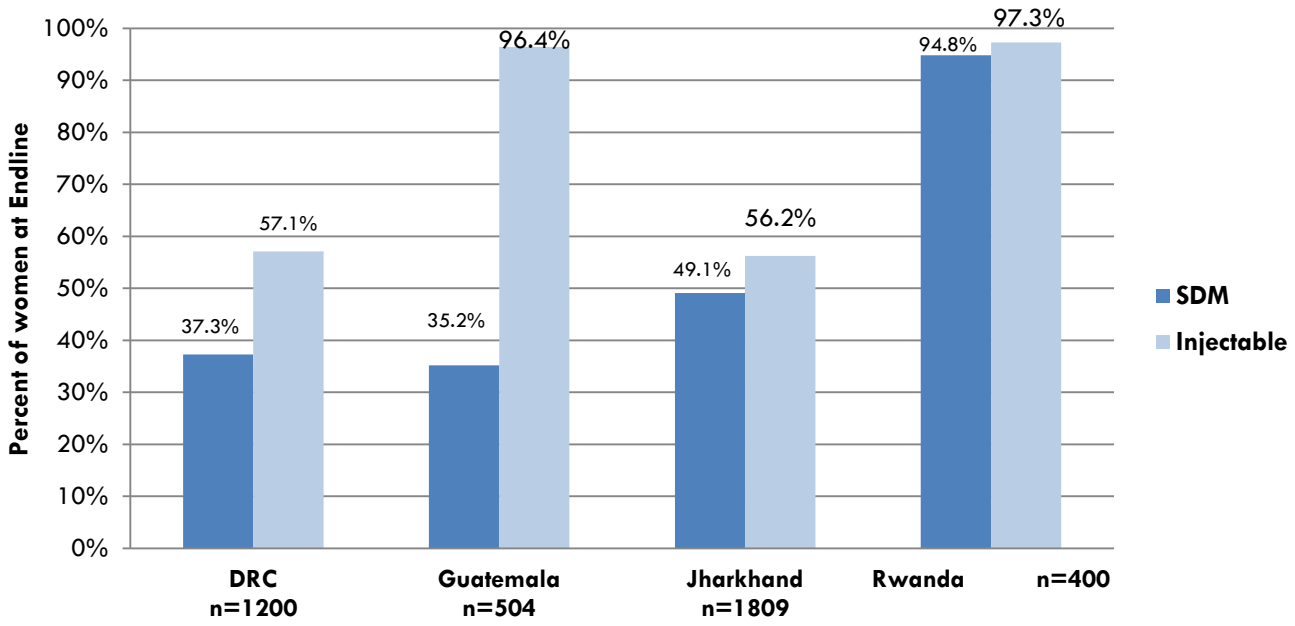
SDM expansion at scale was achieved by working in partnership with the MOH and with other organizations engaged in FP provision and support. Important among the latter were large-scale projects funded by international donors and implemented by CAs. While the strategy of working with such projects (often called 'bilaterals') was positive in terms of leveraging resources for scale-up, it also had negative implications. Projects were finite by definition; when they ended, so did resources to support scale-up. In addition, most bilaterals operated regionally and not nationally, leading to coverage gaps. This affected the pace of horizontal scale-up in all five countries. IRH responded by working more directly with the MOH in under-resourced areas and identifying other partners in the public and private sectors. FBOs played a major role in service provision in Rwanda, for example, and direct-to-consumer approaches were used in all countries to varying degrees.

Awareness of SDM as a FP option

If people were to seek SDM, they had to be aware that it was an option and know where to find it. IRH posited that when SDM was as well-known as other methods, demand for it would rise at least to levels seen in operations research and introductory phases. IRH and partners used an array of channels to introduce SDM information to women and men: person to person, print media, clinic and community-based promotion and mobilization, and mass media. These demand creation tactics are the topic of Chapter 3.4.5; the focus here is on the results of demand creation.

SDM awareness grew during the scale-up phase but by endline, country studies indicated that there were still awareness gaps of SDM compared to other methods in Guatemala and DRC. In India/Jharkhand and Rwanda, awareness of SDM became comparable to (and occasionally higher than) other user-directed methods such as oral contraceptives or injectables. Trends were similar among men and women. Figure 4 shows women's knowledge of SDM compared to their knowledge of injectables at the end of the scale-up phase.

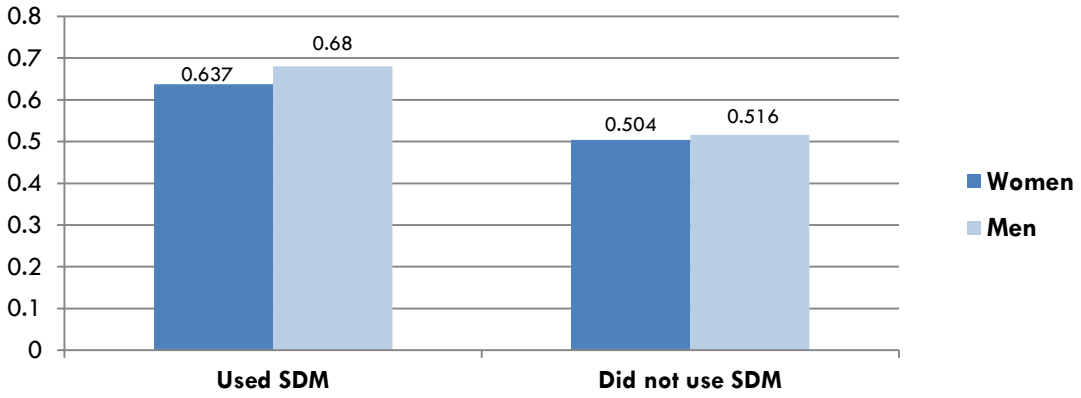
Figure 4: Percent of women who were aware of SDM and injectables at endline



Further analysis in countries that conducted both baseline and endline surveys indicates that awareness was unequal across sub-populations: Older, more literate women, and those with more children, were significantly more likely to have heard of SDM, as were those who worked outside the home. (See Appendix D for data on men and women's awareness of additional methods.)

Positive community attitudes towards an innovation and knowledge of where to obtain it, are important determinants of uptake and diffusion. A method's social reputation, as reflected in community attitudes, must be attractive to positively influence demand. Endline surveys presented all women and men who had heard of SDM a series of opinion statements, each phrased both positively ("SDM is easy to understand," for example) or negatively (SDM is difficult to understand").[28]. To create an attitude index, positive statements were coded 1 if yes, 0 otherwise. Negative statements were coded 1 if no, 0 otherwise. Codes were added, and divided by the number of items, to arrive at a scale ranging from 0 (meaning a poor opinion of SDM) to 1 (a positive opinion). The scores reflected a moderately positive attitude toward SDM, with little difference between men's and women's opinions. Scores for women and men at endline are shown in Figure 5. Not surprisingly, among those who had heard of the method, the opinions of those who had used it were more positive than those of respondents who had not. Men had slightly higher index scores than women.

Figure 5: Attitudes towards SDM (Score of 8-item index)



Source: IRH Household Surveys, 2012 and 2013

IRH and partners made a concerted effort to overcome gender barriers that prevented men and women from meeting their FP needs. Chapter 3.5.2.3 discusses this work, and presents several outcomes about men's knowledge of SDM and participation in its use.

SDM use and its contribution to FP planning programs

As a rule, demand helps determine the added value that a new method brings to a FP program. IRH posited that, when SDM was as well-known as other methods, demand for it would be sufficient to demonstrate its contribution to the method mix. Policy makers and program managers needed information on numbers of

[28] SDM (CycleBeads) is easy to use, SDM (CycleBeads) is affordable, and SDM (CycleBeads) is an effective method in preventing pregnancy when used correctly, SDM (CycleBeads) is hard to understand, SDM (CycleBeads) is hard to obtain, and Few women use SDM (CycleBeads) in community.

new SDM users and the relative contribution of SDM to contraceptive prevalence, including data on uptake and continuation. Also of interest to policymakers was evidence from small-scale studies that SDM acted as a method gateway, motivating people who had never used modern methods to seek FP services; would this hold true when SDM was offered at scale?

Across all five countries, 15% of women who had heard of the method chose to use it, and 48.5% of ever users were still using it at the time of the survey. Among men who had heard of the method, 12.6% chose to use it, and of those, 38.5% were still using it. Importantly, of the 334 women surveyed who had ever used the SDM, 19.8% were first time FP users, a finding that suggests that offering SDM continues to bring new users to FP when provided at scale, as was found in the pilot studies.

Of the 334 women surveyed who had every used SDM, 19.8% were first time FP users, a finding which suggests that offering SDM brings new users to FP when provided at scale.

Figures 6 through 9 show the proportion of SDM users compared to users of other methods, by country. Earlier SDM research in smaller geographic areas[29] indicated that between 3% and 6% of new FP users could be expected to choose SDM. IRH's endline findings fall within that range, except in DRC and Rwanda, where SDM use was higher.

User characteristics and satisfaction

The mean age of SDM users across all five countries was around 30 in all countries, and mean parity ranged from 2.7 to 2.9. SDM users included Catholics, Christians, Muslims and Hindus, as would be expected given the range of countries included in the study. About 10.4% of users had no formal education and 63.6% had completed primary education or higher. 79.9% were literate and 51.6% worked outside the home. Multivariate analysis revealed that education and literacy appear to be significant factors in SDM use. Literate and more educated women were more likely to have heard of SDM. Furthermore, among all women who were aware of SDM, literate women were more likely to choose and continue using SDM.

Among current SDM users at the time of endline surveys, 97.5 % of women and 98.8 % of men were satisfied with the method (79.5 and 63.4%, respectively, were very satisfied). Some 87% of women and 78% of men stated that they planned to continue using SDM. More than half (53.3%) of women who had discontinued SDM use were using a modern FP method at endline (excluding women who discontinued due to planned or unplanned pregnancy, or marital dissolution). This latter finding is noteworthy because it indicates that SDM use *does* lead to other method use for a majority of users, once SDM is no longer the method of choice for a woman or couple.

[29] Gribble, J., Lundgren, R., Velasquez, C., and Anastasi, E. 2008. "Being strategic about contraceptive introduction: the experience of the Standard Days Method." *Contraception; 77*(3): 147-154.

Figure 6: DRC Family Planning Method Use Among Women Currently Practicing FP

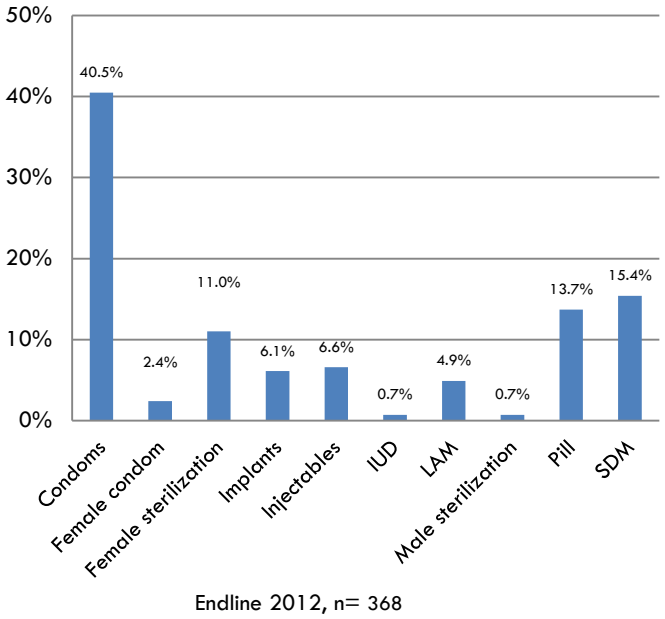


Figure 7: Guatemala Family Planning Method Use Among Women Currently Practicing FP

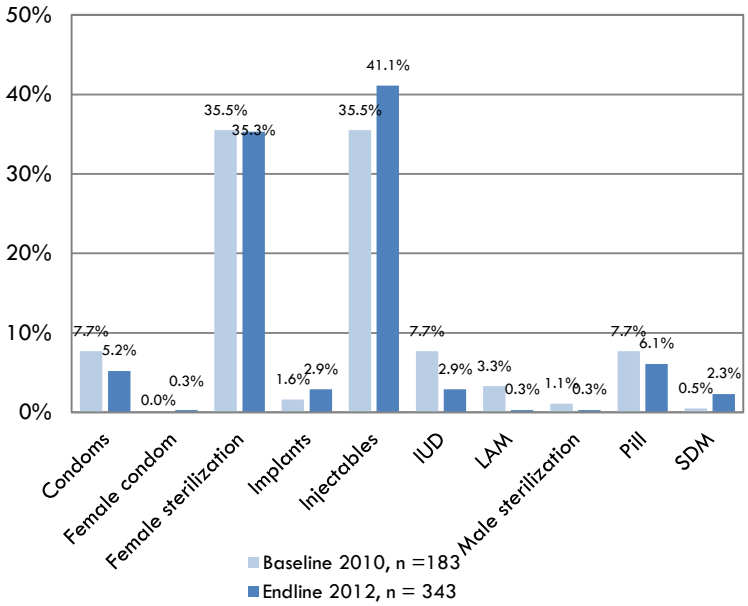


Figure 8: Rwanda Family Planning Method Use Among Women Currently Practicing FP

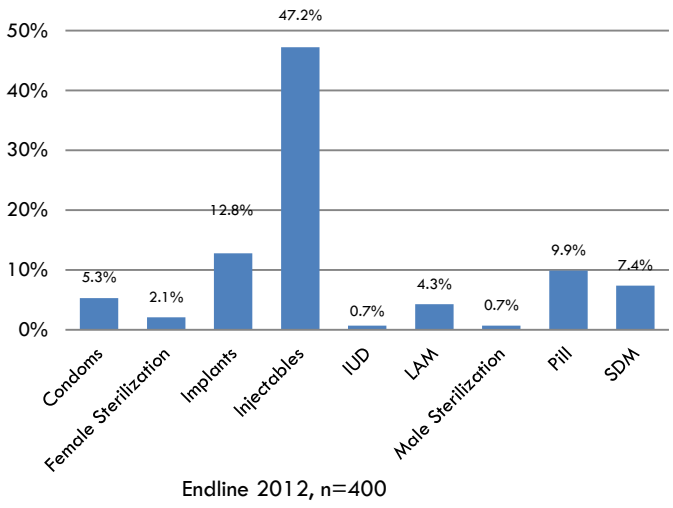
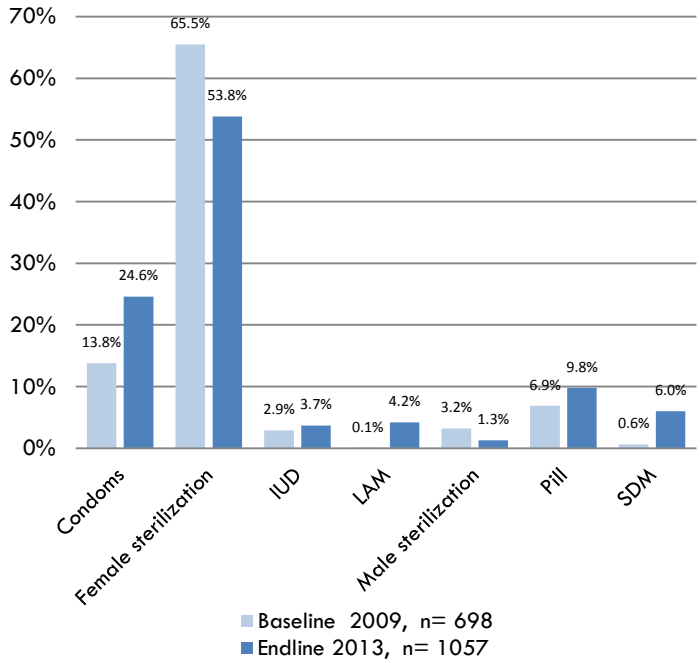


Figure 9: India Family Planning Method Use Among Women Currently Practicing FP



Source: IRH Household Surveys

A recognized risk of scale-up is that an innovation's effectiveness may decrease as the rigorous quality control measures that are a hallmark of pilot studies taper off. To assess whether SDM scale-up resulted in less effective use of SDM, the endline research asked current and former SDM users to demonstrate the use of CycleBeads. Interviewers marked which of six items users spontaneously mentioned. A scale was constructed that ranged from 0 (user did not mention any item) to 1 (user mentioned all items). The mean score for current female users was 0.72; former female users scored 0.59. Men showed similar results: current male users scored 0.70, and former scored 0.52. (It was not surprising that current users demonstrated a better grasp of CycleBeads; those who stop using the method may quickly forget the details of its use.) An analysis using logistic regression, where the correct-use scale (for women) was the dependent variable, showed that age, parity, and literacy had no statistically significant effect on correct use. That is, women of all ages, regardless of the number of children they had, whether literate or not, were using SDM correctly.

To assess whether difficulty of use is a reason for abandoning SDM, IRH examined the reasons that women gave for discontinuation. The three most common reasons for discontinuation were: women became pregnant (28.2% of discontinuers). (The survey did not ask if the pregnancy was planned or unplanned so interpretation of this finding is limited.) About 19% of women who stopped using SDM did so because their cycles were out of range. Another common reason (10.6%) for discontinuation was that women wanted to become pregnant. Few women (4.7%) thought that SDM was difficult to use or hard to understand. A very small proportion of women cited difficulties with the method: 4.7% said that partner involvement was problematic, while 3.5% said that family members disapproved of the method.

In sum, endline results suggested that SDM users represented an important proportion of FP users. When offered at scale, SDM continued to bring new users to FP, discontinuation rates were low, and women were likely to continue using modern contraception of some sort once SDM no longer met their needs. Overall satisfaction with and knowledge of SDM were good among both female and male users. Results suggested that awareness of SDM had grown, and that IEC and social mobilization activities had created a positive and realistic view of the method among community women and men.

3.2.2 Extent of SDM Institutionalization: Vertical Scale-Up

The systems approach to scale-up not only fostered the expansion of SDM services, it ensured the method's institutionalization. Guided by the ExpandNet framework, IRH identified and collaborated with in-country partners to institutionalize SDM in structures and systems. As Table 6 shows, vertical scale-up was largely successful.

Table 6: Extent of Institutionalization *Source: FAM Project M&E reports*

	Aimed for sub-national scale-up			*Aimed for national scale-up*	
SDM…	**DRC**	**Guatemala**	**India**	**Mali**	**Rwanda**
Is written into key norms & procedures documents	√	√	√	√	√
Is in nurse / community health worker training curricula and supervision forms	√	√	√	√	√
Has its own reporting line in MOH HMIS	√	In process	Not yet	√	√
Is in logistics systems inventory/distribution forms	√	In process	√	√	√
Is in donor and/or MOH procurement tables	√	Not yet	Not yet	√	√

Reflecting upon vertical scale-up across time and countries, the early and easy 'wins' were technical in nature: inclusion of SDM in norms and procedures, and integration into training curricula. Other wins took longer, such as SDM's integration into HMIS and logistics systems. IRH's experience was that such systems tended to be revised every five or six years, and revisions did not always coincide with the SDM scale-up phase.

The most difficult challenge, not fully resolved at the close of the scale-up phase, was to incorporate SDM/CycleBeads into procurement systems and to secure governments' and/or donors' financial commitments to purchase CycleBeads. This was a critical, unresolved issue in Guatemala and India where there was no historical precedent of CycleBeads commodity purchases by donors. (That said, the addition of APROFAM as a private sector distributor may address this challenge in Guatemala). In Mali, sufficient supplies of CycleBeads during scale-up meant that there was no historical precedent of donor purchase (IRH had donated stock prior to the scale-up phase), although USAID and the MOH have included CycleBeads in their procurement lists. Since CycleBeads were already purchased by USAID in DRC and Rwanda, the probability was greater that procurement would continue in those countries. In DRC, however, even this precedent was problematic because USAID only procured commodities for the health zones it supported, leaving an important part of the country without a CycleBeads donor. Procurement and donor support of CycleBeads are also discussed in Chapter 3.4.7.

3.2.3 Environmental Factors Influencing Scale-Up

An analysis of the political environment in the five scale-up countries showed that political support for SDM scale-up was inconsistent. In each country, some political forces supported SDM while others hindered its scale-up. Stakeholder interviews at endline (Table 7) confirmed IRH and partner analyses. In DRC and Rwanda, it was clear that positive forces outweighed opposing forces (and will continue to do so for the near future), but it was less clear which forces would prevail in India, Guatemala, and Mali.

Table 7: Summary of stakeholder opinions on political forces affecting SDM scale-up

	Supporting Forces	Opposing Forces
DRC	• Strong government/MOH support for FP revitilization includes SDM • Natural FP/SDM well accepted in cultural-religious social context • Strong USAID Mission support	• Pronatalist values support large families • European donors supporting FP have not made strong commitment yet to ensuring SDM is part of programs they support
Guatemala	• Law on universal access to FP allowed space for integrated FP programs	• UNFPA would not purchase CycleBeads • Church not supportive of SDM • Weak support from USAID Mission • Many political changes within MOH led to uncertainties about including SDM as a FP option
India	• Jharkhand State government supportive of FP/SDM (contributed financial resources)	• National government focuses on sterilization rather than integrated FP programs • Neutral USAID Mission support for facility-based SDM • Many political changes within MOH led to uncertainties about SDM option

Mali	• Solid MOH support for SDM in FP programs in facilities and communities • Key Muslim leaders support SDM option	• Pronatalist values support large families • Weak USAID Mission support • Relative donor and government preference for LAPM, LARC*
Rwanda	• FP is part of national development agenda • Strong MOH support for SDM in FP programs at facilty and community levels • Strong Catholic Church support for SDM option	• Relative donor and government preference for LAPM, LARC • Other government policies (eg, performance-based financing) not supportive of SDM option • Neutral USAID Mission support

Source: IRH Endline Stakeholder Interviews
**Long-acting and permanent methods (LAPM), long acting reversible contraception (LARC)*

Two important macro-environmental factors influenced the potential sustainability of SDM scale-up. These were donor procurement of CycleBeads (see Chapter 3.4.7 for further discussion) and a focus within the global FP community on LAPM and LARC, rather than on a larger range of FP method options (Chapter 3.3.2).

3.2.4 Remaining Work to Achieve Sustainability

As noted earlier, within a given country the probability of sustaining widespread SDM integration into FP programs depended on a interlinked set of critical factors. The interplay of these influences discussed above underlines the importance of strategizing and maintaining a balance along the horizontal and vertical scale-up axes and mitigating negative environmental forces. They also serve to remind us that scale-up is not just about norms and training.

IRH developed thresholds for the six factors indicating what level of achievement we think would be necessary for sustainability to take hold (text box). Achievement of these thresholds has been discussed in relation to the data presented in Sections 3.2.1, 3.2.2, and 3.2.3. To provide a visual synthesis of the data, IRH created radar graphs (Figure 10) that collapse the six thresholds of scale-up success into five main domains of sustainability as shown in Table 8.

Achieving the sustainability tipping point: Thresholds of scale-up success

The probability of sustaining SDM integration depends on many interlinked factors, with sustainability thresholds defined as:

- SDM services are available at national or near-national level
- SDM integrated into all or nearly-all key documents and FP support systems
- Community knowledge of SDM is equal to other FP methods
- Community support exists for SDM (attitudes towards SDM are more positive than negative + demand for SDM is an important proportion of all FP method use)
- Political will to support integration, including policymaker conviction of SDM's added value, is more positive than negative
- Interplay of macro-level forces influencing FP, including government and donor support, is equally supportive of SDM compared to other FP methods

Table 8: SDM Scale-up Domains of Sustainability

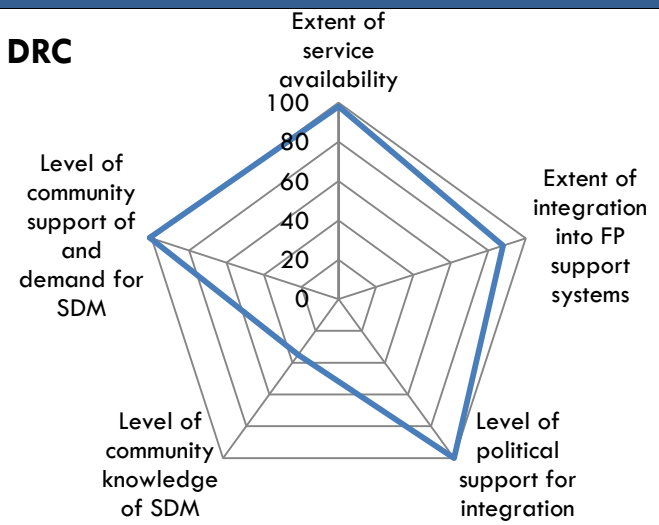
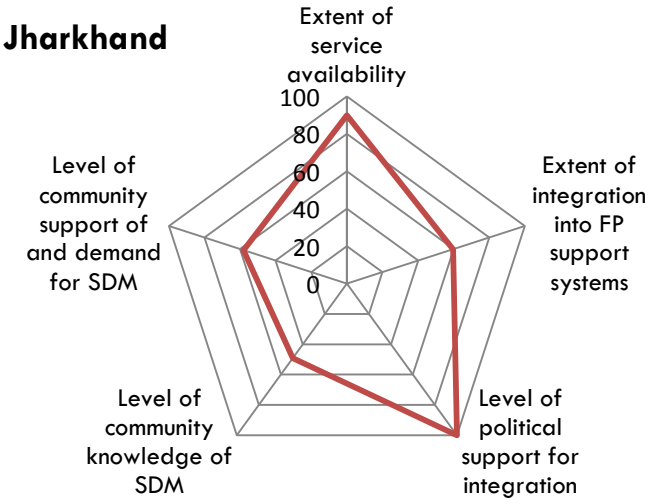
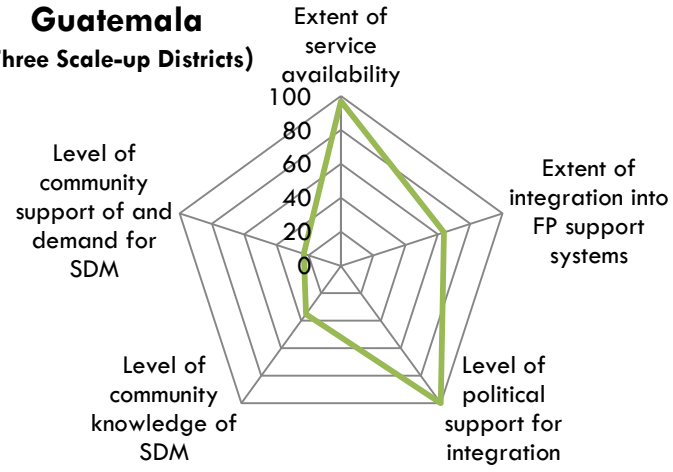
Domain of Sustainability	Definition
Extent of service availability	Percent of benchmark target reached for Service Delivery Points
Extent of integration into FP support systems	Percent of benchmark target reached for vertical integration (composite of pre-service, in-service, donor procurement, logistics systems, HMIS, and IEC efforts)
Level of political support for integration	Percent of benchmark target reached for key policies, norms, guidelines and protocols
Level of community knowledge of SDM	Percent of women who heard of SDM at endline
Level of community support of and demand for SDM[38]	Percent of women who practice FP

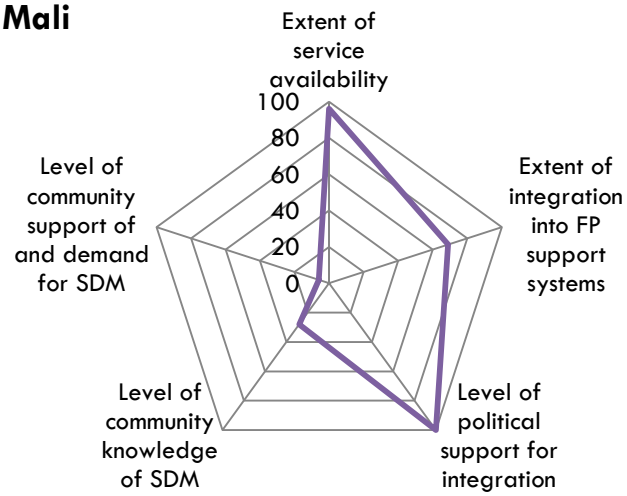
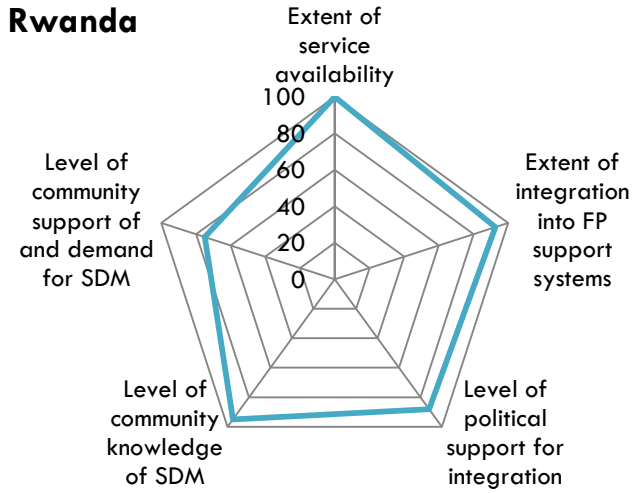
To maintain comparison across all five countries, targets that exceeded 100% (specifically, the level of political support for integration and the level of community support of and demand for SDM in DRC and the extent of service availability in Rwanda) were capped at 100%. Ultimately, the more complete the shape of the pentagon, the more sustainable SDM is likely to be (Figure 10).

Viewed together, these data suggest that scale-up of SDM will be sustained in Rwanda and in Mali (dependent on resolution of political instability in the latter country). Guatemala and India, where SDM scale-up was regional or sub-regional rather than national, were more vulnerable to setbacks. DRC will likely continue to expand SDM as FP programs are revitalized over the next several years, particularly if the issue of CycleBeads security is resolved to ensure access to health zones supported by donors other than USAID.

[38] Figures for level of community support of and demand for SDM were multiplied by a factor of 10 across all countries to allow proper display on the graphs as they were originally less than or equal to 10.

Figure 10: Radar Graphs of Domains of SDM Sustainability

Country-Specific Radar Graph	Crucial remaining items for sustainability
DRC 	• Expand availability of CycleBeads beyond USAID-supported regions (UNFPA, IPPF, other donors) • Ensure non-USAID-funded NGOs can access CycleBeads • Improve logistics and supply chain for all contraceptive methods, including CycleBeads • Advocate for CycleBeads inclusion in DKT social marketing program • Advocate for CB procurement with UNFPA, WHO, GIZ, PARSS, and DfID for their areas • Continue advocacy for SDM in 2014 DHS
Jharkhand 	• Advocate for SDM in national-level policies and programs (e.g. ASHA, accredited SM products) • Expand to remaining 12 districts in Jharkhand • Reinforce SDM/LAM providers
Guatemala **(Three Scale-up Districts)** 	• Address international donor support for CycleBeads procurement • Strengthen CycleBeads logistics system • Improve reporting of SDM at the facility level • Fund M&E visits to public/private health posts

Mali 	• Support mass media SDM promotion (male involvement spots created by PSI) to maintain sales
Rwanda 	• Broaden international donor support for CycleBeads procurement • Overcome logistics barriers of introducing an underutilized method • Ensure FBOs are connected to the public sector distribution system • Re-include SDM in performance-based financing • Ensure continuation of CycleBeads through social marketing

3.3 How was Scale-Up Achieved? Assessing and Responding to System Elements

3.3.1 Overview

The ExpandNet framework urges a systems approach to scale-up; that is, to position scale-up as a process that occurs within a system of interacting elements, both global and local. A systems approach clarifies that scale-up of a health innovation cannot be solely a technical undertaking, unaffected by the outside world. It is heavily influenced by environmental factors,[39] but scale-up actors can, in their turn, influence system elements in ways that advance scale-up and indeed strengthen health structures overall. This section discusses how those elements expressed themselves in the five scale-up countries, and how IRH and partners influenced, and were influenced by, those elements as they pursued SDM scale-up.

[39] World Health Organization and ExpandNet. 2009. *Practical guidance for scaling up health service innovations*. Geneva: WHO Press. Page 7.

3.3.2 The Environment: Global Forces' Effects on SDM Scale-Up

Global forces such as *donor priorities and technical directives* heavily influenced scale-up work at the country level. USAID and WHO are two of the most important forces in global FP, as donors (USAID has been the lead funder of international FP for more than 40 years) and as technical experts. Table 9 summarizes the ways in which they facilitated and hindered scale-up; the subsequent narrative provides greater analysis.

Table 9: Summary of USAID and WHO Influence on Scale-Up

	Factors that helped SDM scale-up	Factors that hindered SDM scale-up
USAID	• SDM fits well within USAID's healthy timing and spacing of pregnancy (HTSP) initiative • USAID's emphasis on community-based provision of FP methods was appropriate for SDM • USAID's inclusion of SDM in several 'high impact practices' aided global, but not national, scale-up	• USAID's emphasis on LAPM, LARC and community-based injectables detracted from SDM work • USAID's exclusion of SDM from projects emphasizing long acting methods meant fewer resources for SDM than for other methods • Single-method promotional campaigns, such as for IUDs and injectables, left out other methods
WHO	• WHO recognized SDM as an evidence-based practice and included it in its technical and program guidance documents in 2000 and 2007[40,41,42,43] • WHO provided policy guidance for CycleBeads procurement	• Exclusion of CycleBeads from the WHO essential medicines and essential commodities lists inhibited UNFPA and government support for SDM • CycleBeads were not included in UNFPA's procurement catalog until 2012, and this created challenges in procuring CycleBeads outside of USAID mechanisms in Guatemala, DRC and Rwanda.

USAID: Two USAID technical priorities[44] had a positive effect on SDM scale-up. First was its promotion of HTSP, a good fit because SDM helps couples achieve optimal birth spacing. In fact, IRH played an active role in the HTSP, organizing several global technical panels in support of the initiative. This provided IRH opportunities to collaborate with key actors working at the intersection of FP and maternal and child health (MCH), thus further legitimizing SDM scale-up. In India, for example, where spacing methods were long de-emphasized in favor of sterilization, growing interest in HTSP contributed to the Government of Jharkhand's support for SDM.

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[40] World Health Organization. 2010. *Medical eligibility criteria for contraceptive use*. 4th edition. Geneva: World Health Organization. http://www.who.int/reproductivehealth/publications/family_planning/9789241563888/en/index.html. Accessed September 2013.

[41] World Health Organization. 2004. *Selected practice recommendations for contraceptive use*. 2nd edition. Geneva: World Health Organization. http://www.who.int/reproductivehealth/publications/family_planning/9241562846index/en/index.html. Accessed September 2013.

[42] Hatcher, R.A., Trussell, J., Stewart, F.H. Contraceptive technology. 18th ed. New York: Ardent Media, Inc; 2004.

[43] World Health Organization Department of Reproductive Health and Research and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, INFO Project. Family planning: a global handbook for providers. Baltimore and Geneva: CCP and WHO, 2007.

[44] United States Agency for International Development. *Family Planning Program Priorities*, April 2013. http://www.usaid.gov/sites/default/files/documents/1864/fp_overview.pdf. Accessed September 2013.

Second, the USAID focus on community-based FP approaches, including engaging community health workers to bring information and services to underserved areas, provided opportunity to demonstrate the benefits of including SDM in the method mix. USAID selected the provision of FP methods, including SDM, by trained community health workers for its list of 'high-impact practices.'[45] This contributed to SDM's legitimization and facilitated its scale-up in India (through Accredited Social Health Activists or ASHA), Mali, Rwanda (through MOH and NGOs), and Guatemala (with community health workers and traditional birth attendants who were trained in SDM). On the other hand, much of USAID's focus on community-based approaches was on injectables, which consumed considerable resources and attention in country programs and, in most settings, detracted from SDM scale-up.

The priority USAID placed on LAPM and on LARC negatively affected SDM scale-up. A number of USAID's requests for proposals emphasized these categories of contraception, and often neglected SDM or other methods; this resulted in insufficient resources to support SDM integration. USAID's emphasis influenced NGOs and CAs, policy-makers and providers at the country level. Regrettably, this outweighed the areas in which USAID was supportive of SDM. In Rwanda, for example, sterilization and LARCs dominated the FP agenda while SDM scale-up was underway. In India's Jharkhand state, a high-profile effort to promote IUDs was intended to expand access and choice, but the initiative made no mention of SDM among the FP options available.

WHO: An important legitimizing factor for SDM scale-up was its inclusion in WHO's major FP publications, commonly referred to as the 'four cornerstones' of effective FP use.[46] WHO also issued policy guidance pertaining to CycleBeads procurement.[47] But WHO did not include CycleBeads on its Essential Medicines or Essential Commodities List.[48] This had significant, negative ramifications for commodity support to SDM scale-up, particularly since UNFPA adheres to WHO policy guidance.

UNFPA is a major provider of FP supplies, particularly in areas not served by USAID. UNFPA declined to purchase CycleBeads, citing lack of evidence of effectiveness and impact. As discussed in Chapter 3.4.7 (Procurement), this was detrimental particularly in DRC and Guatemala. Ideally, of course, all MOH-approved methods should be available in all areas of a country, regardless of which entity procures the related commodity. (This policy area is still evolving, and CycleBeads may be included in future UNFPA procurements.)

WHO had a positive impact on scale-up in unanticipated ways. For example, IRH's use of the WHO-endorsed ExpandNet framework for scale-up was a legitimizing factor in the eyes of several governments.

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[45] United States Agency for International Development. *High Impact Practices in Family Planning*, July 2013. http://www.fphighimpactpractices.org/resources/high-impact-practices-family-planning-list. Accessed September 2013.
[46] These documents are *Medical Eligibility Criteria for Contraceptive Use*, *Selected Practice Recommendations for Contraceptive Use*, *Decision Making Tool for Family Planning Clients and Providers*, and *Family Planning: A Global Handbook for Providers*. For more information: http://www.who.int/reproductivehealth/publications/family_planning/en/index.html.
[47] World Health Organization Department of Reproductive Health and Research. 2012. *How to Procure CycleBeads: A Visual Tool for the Standard Days Method*. Geneva. http://www.who.int/reproductivehealth/publications/family_planning/rhr_12_14/en/index.html. Accessed September 2013.
[48] World Health Organization. 2013. "WHO Model Lists of Essential Medicines." http://www.who.int/medicines/publications/essentialmedicines/en/. Accessed May 2013.

Global concern was growing that successfully piloted, evidence-based practices were not being sustainably scaled up, and IRH's work to monitor and evaluate scale-up attracted much discussion at the global and national levels. In Guatemala, India, and Rwanda, in particular, stakeholders who were involved in the scale-up process incorporated the ExpandNet framework into their thinking.

In sum, global FP forces both helped and hindered SDM scale-up: policy decisions made in Washington and Geneva had dramatic impact at the country level. Scale-up benefited from SDM's inclusion in WHO's international FP norms and the alignment of SDM integration with some of USAID's technical priorities. Unfortunately, the global emphasis on permanent methods and LARCs, and the exclusion of CycleBeads from key procurement mechanisms, placed SDM at a disadvantage and threatened the long-term sustainability of SDM services.

3.3.3 The Environment: Country-Level Forces' Effects on SDM Scale-Up

> "[Family planning/birth spacing] is not a priority of the government here. In NFHS-2 [a major household survey], complete immunization was 8%, and now in NFHS-3 it is 39% because the entire system was geared up to work on immunization. There is a core group [of development partners] that work for immunization. The Government has created this group. Now, if the Government creates a similar core group for birth spacing, only then can it become a priority."
>
> Stakeholder in Jharkhand

Other environmental forces with significant effect on SDM scale-up were *institutional and political support* and *socio-cultural influences* at the country level. The success of IRH and its partners in mitigating or leveraging environmental forces depended in large part on their ability to identify them and mobilize action. Environments are never static, and it was important to continuously scan for and respond to emerging changes. Over five years, IRH and partners drew several conclusions related to country-level forces.

Consistent government support facilitated the scale-up process.

Consistent, supportive MOH leadership in planning and coordination was an important factor in scale-up success. The strong leadership and support of Rwanda's MOH-led MCH Task Force and Family Planning Technical Working Group, for example, ensured that all FP partners included SDM in their work. The MOH in Mali led a participatory process to engage partners in the development and implementation of a multi-year strategic plan for scale-up.

Changes in MOH leadership often led to setbacks, and this was particularly noticeable in Guatemala and India. IRH obtained a written commitment from Guatemala's MOH for SDM scale-up, and a new law ensured universal access to FP. Still, the resource team perceived that a potential change in the government posed the biggest threat to the success of scale-up in that country. The leader of the Guatemalan MOH's reproductive health division changed three times during the scale-up phase, requiring the resource team to engage in repeated advocacy with each new team.

In India's Jharkhand state, Ministry of Health and Family Welfare (MOHFW) leadership also changed repeatedly during scale-up, creating uncertainty and inconsistent support. IRH advocated anew with each change, and made the most of particularly supportive leaders. For example, when the resource team perceived that one minister was strongly committed to SDM expansion, it established a memorandum of

understanding with the government. This provided legitimacy for scale-up and resulted in vital funding for trainings and educational materials over time.

Unfortunately, an extreme example of the consequences of political instability occurred in Mali, where a *coup d'état* in 2012 caused scale-up activities to be suspended, with several key components left unfinished.

Political support for FP as a national development strategy facilitated scale-up.

In Rwanda, FP programs languished in the post-genocide period. By the early 2000s, however, the government determined that strengthening services to address high fertility rates was a foundation for attaining national development objectives. Its national commitment to strong FP programs led to effective coordination mechanisms such as the MCH Task Force and its sub-group, the Family Planning Technical Working Group; both served as mechanisms to systematically coordinate SDM scale-up. Even local-levels administrations promoted FP because it contributed to national development goals. The governments of DRC and Mali also made FP a priority, which fostered opportunities to integrate SDM into national programs.

In contrast, while the Jharkhand MOHFW supported SDM scale-up, political will to promote birth spacing methods was weak. For many years, India's FP program focused on sterilization, and accorded low priority to birth spacing. More recently, greater emphasis was placed on issues such as immunizations and institutional deliveries. These factors made it difficult to galvanize partners into a strong coalition to promote birth spacing.

The effects of religion and culture on SDM scale-up could be strongly positive or negative.

In Guatemala, the Catholic Church opposed FP, including SDM even though it is a natural method. But in Rwanda and DRC, the resource teams leveraged the interest of faith groups to expand access to SDM. In DRC, for example, the population is deeply religious and a large proportion of health services are provided by FBOs, both Catholic and Protestant. IRH actively engaged FBOs to accelerate the spread of and demand for SDM. Chapter 3.5.3.1 further discusses FBOs' role in SDM scale-up.

> "This [method] is seen as less harmful to one's health. Religious organizations have been very receptive to CycleBeads; I'm sure that some churches are going to begin to be more flexible, because there we've encountered more clashes with other methods."
>
> - District-Level MOH Official in Guatemala

> "In the political realm, there is a double standard. Politicians say that [contraceptive] methods are a form of abortion, but they and their families use them. They are thinking about religion, but for others."
>
> - Member of a Guatemalan health association

> "Working with religious leaders has allowed for greater acceptance of SDM because of the great trust people put into these leaders."
>
> - Stakeholder in DRC

Regardless of Church positions and politics, cultural appreciation of a natural FP option likely facilitated SDM uptake in some countries. Stakeholder interviews and anecdotal information in Guatemala and DRC, especially, indicated that cultural acceptability of SDM was a positive force. In Guatemala, the wide array of

belief systems among indigenous groups created a base for materials development and outreach, creating culturally appropriate messages to promote SDM.

Donor priorities for other FP methods made SDM scale-up more difficult

While the influence of donors' global priorities was felt at national levels, as discussed above, the FP preferences of policymakers and donors *within* each country also influenced scale-up. Some favored the inclusion of SDM alongside other methods in the basket of contraceptive choices. Mali's MOH and USAID Mission, for example, demonstrated consistent support of SDM by incorporating it into bilateral projects, although follow-through with implementing projects, e.g., ensuring that technical support for SDM was done to the same extent as other methods, was not consistent. In DRC, SDM appealed to policymakers because it did not require resupply, an advantage in the conflict/post-conflict environment with its weak supply network. Early and consistent USAID involvement demonstrated policy support to all FP stakeholders in DRC and resulted in widespread inclusion of SDM in existing and new programs.

But SDM was viewed less favorably in the other three countries. In Rwanda, despite the method's strong social and cultural acceptability, the FP policy discourse shifted toward promotion of LAPM, and this siphoned attention and resources from SDM expansion. USAID in Rwanda stopped providing field support funding to IRH in 2008, affecting the ability of IRH and partners to raise awareness of SDM at the same time that major demand creation efforts were taking place for other methods. India's national FP program did not include SDM because it was less effective than LAPM; Jharkhand state was therefore unable to procure CycleBeads via the national government as it did other methods. In Guatemala, USAID ceased all funding for SDM scale-up in 2010, and a major bilateral project[49] did not include SDM in its budget or work plan.

UNFPA's lack of support for SDM strongly influenced scale-up within all five countries. In Rwanda, UNFPA played an important FP policy role but never publicly supported SDM inclusion. It was the major procurer of FP commodities in Guatemala, but despite SDM's incorporation in MOH policy and standards documents, CycleBeads were not on the UNFPA list of contraceptives. Similarly, IRH and the MOH in DRC could not convince UNFPA to purchase CycleBeads for health zones supported by the latter.

Some environmental factors were beyond IRH influence.

Several environmental factors affected scale-up for better or for worse, and were largely beyond the control or influence of IRH and resource teams. The conflict that plagued parts of DRC threatened health systems and structures already weakened by decades of poor governance. In Jharkhand, violence committed by Maoist separatists made work difficult in certain areas. Also in Jharkhand, a corruption scandal related to the purchase of health commodities in Jharkhand made it virtually impossible for the state to purchase CycleBeads at one point. More positively, administrative decentralization in Mali and Jharkhand facilitated scale-up, because regions/districts/NGOs could take certain actions without approval of the central government and could use their own resources to advance SDM.

3.3.4 Resource and User Organizations

In all scale-up countries, the MOH was both the primary *resource organization*, (it promoted and facilitated expansion and institutionalization of SDM) and *user organization* (it adopted and implemented SDM).

[49] Support for International Family Planning Organizations Project (SIFPO).

IRH and MOHs engaged a range of partners as resource organizations, formed into resource teams, in all countries but DRC. The partners included donors (such as USAID and UNFPA), international NGOs (such as Save the Children and PSI), national NGOs and FBOs. IRH's role was to provide overall guidance and support to scale-up, in effect serving as a 'resource organization to the resource organizations.' The majority of user organizations, meanwhile, were the various types and levels of MOH health services, some of which were supported by bilateral projects with important financial resources. Other user organizations were FBO services, family planning NGOs, and social marketing agencies.

Several factors contributed to resource organizations' effectiveness in meeting the needs of user organizations for SDM integration and scale-up:

A mandate from the MOH gave legitimacy to the resource team.
The importance of the MOH as a partner cannot be overstated. In all five countries, the MOH or a division within it was perceived as the national leader of FP activities. It played an essential role by providing the mandate for SDM scale-up and giving legitimacy to other resource organizations. The effect of this mandate was stronger when MOH took an active leadership role on the resource team.

While written or verbal statements from the MOH were important, scale-up was greatly facilitated when high-level MOH staff actively championed SDM. The head of Mali's Division of Reproductive Health, for example, was a strong advocate throughout the SDM introductory and scale-up phases. In DRC, the MOH's championship—for example, including SDM in FP training materials and advocating for partners to integrate the method—was cited by the IRH Country Representative as the single most significant determinant of scale–up in that country.

Guatemala and India (Jharkhand) obtained written commitments from the MOH but saw frequent changes of MOH leadership. During periods when no strong leader was in place, ongoing advocacy was required to ensure that MOH and other key stakeholders maintained their commitments to the scale-up process.

A designated resource team facilitated scale-up.
IRH and the MOH in four of the five countries developed a *resource team*, or a central coordinating mechanism for systematic collaboration among resource organizations. The composition, role and strength of the resource teams varied (Table 10). DRC did not have a country-wide coordinating mechanism for resource organizations.

Table 10: Resource Team Characteristics

	Name	Role in scale-up	Pre-existing or created for scale-up?	Members / attendees (in addition to IRH)	Frequency of meeting
Rwanda	MCH Task Force	Primary oversight	Pre-existing	MOH, donors, international and national NGOs, FBOs working in MCH and FP	Quarterly
	FP Technical Working Group (sub-group of above)	Technical input	Pre-existing		Quarterly
Guatemala	Family Planning Resource Team	Oversight & coordination	Created for scale-up	13 members of 7 organizations including MOH, international and national NGOs, donors	Monthly
Mali	Scale-up review and planning meetings	Planning & coordination	Created for scale-up following initial strategic planning meeting	19 organizations including MOH divisions, donors, international and national NGOs, bilaterals	Annual
India (Jharkhand)	Scale-up Partners Meeting (state level)	Oversight	Created for scale-up	Mostly state MOH leaders and district medical officers; some development partners	Semi-Annual
	Core committee meeting (district level)	Coordination	Pre-existing (some created at time of scale-up but purview larger than scale-up)	MOH staff within the district	Quarterly

Example of a Strong Resource Team: Rwanda

In 2011, an Austrian NGO attempted to start a cottage industry, making fertility awareness necklaces in Rwanda as a microenterprise project. The introduction of this beaded necklace in the marketplace would have confused potential users of CycleBeads and could have had a detrimental effect on the reputation of SDM. When the MOH brought this issue to the MCH task force, it was politically charged in that it forced all parties to make a decision with potential diplomatic and financial consequences. In the end, the MCH task force stood up for the integrity of SDM and forced the Austrian NGO to halt production of the fertility necklaces. This represented a victory for the SDM resource team.

In Rwanda, the MOH was well organized and had pre-existing, inter-organizational mechanisms for FP coordination, both technical and programmatic. The MCH Task Force consisted of all development partners involved in that arena, and it had a subcommittee for FP. Partners in both groups committed to strengthening FP programs, including SDM, in the areas of the country in which they worked.

Mali's strong MOH leadership convened and coordinated development partners involved in FP and specifically SDM scale-up. A 2008 strategic planning workshop with all partner organizations resulted in a plan of action and a framework for coordinating all parties' work under the direction of the MOH's reproductive health division. Partners'

meetings were then held periodically to review implementation plans and M&E data.

In Guatemala, the MOH created the Family Planning Resource Team to oversee scale-up. The team provided important opportunities for collaboration and was a mechanism for shared responsibility. At times, the team faced challenges such as some members' lagging interest. But it also experienced successes: getting CycleBeads into the FP procurement tables and integrating SDM into new materials, guidelines and capacity-building activities in public and private sector services.

In Jharkhand, many districts had scale-up oversight committees, consisting of MOH staff, that met quarterly, but there was no state-level coordinating body for FP. Rather, the MOH and IRH convened semi-annual, state-level meetings with district MOH leaders and other development partners. These meetings encouraged ownership, involvement and accountability in scale-up planning and management, but the lack of systematic partner coordination meant some missed opportunities. For example, a USAID-funded bilateral project produced television spots to promote birth spacing methods in Jharkhand but did not include SDM.

> "There is a need for an organization like IRH to steer and advocate and generate evidence. They have provided the technical assistance to develop a road-map."
>
> - Jharkhand stakeholder

> "The process of introducing of SDM…was the same as any other – we get direction from the state and we do it. But, having a partner – IRH – makes a big difference. To start something requires assistance from a development partner. Once the start-up is finished and we are in the maintenance phase, we are okay."
>
> - Jharkhand stakeholder

In DRC, IRH worked one-on-one with a wide range of partners, and fostered alliances between them. MOH ownership of SDM facilitated scale-up across partners, and MOH training manuals facilitated expansion. However, there was no functional coordinating body of FP actors in DRC, and no effective central mechanism for coordination of FP or reproductive health work during the SDM scale-up phase. Consequently, partners did not have a sense that they were part of a larger scale-up resource team.

A designated technical leader to coordinate and lead scale-up was essential.

IRH played the role of 'resource organization to the resource organizations,' providing oversight and technical assistance to scale-up activities. Stakeholders in most countries stated that IRH's guidance and technical support role was crucial.

IRH's role evolved over time. Generally, adapting educational materials and conducting trainings for the resource organizations represented a significant portion of the work at the beginning of scale-up. Other resource organizations were then able to take on the training role, and IRH focused more on quality assurance and systems integration. Table 11 summarizes IRH's most important scale-up roles.

Table 11: IRH's Most Important Scale-Up Roles

Area	Activities
Scale-up strategy	• Orient MOH and resource team to ExpandNet framework • Ensure ExpandNet guiding principles maintained throughout scale-up • Collaborate with MOH, other partners on scale-up strategy (e.g., selection of user and resource organizations, areas for geographical scale-up)
Capacity building	• Develop or revise training materials as needed (beginning of scale-up) • Perform technical reviews of training materials produced by others • Conduct trainings of master trainers (or oversight of trainings of trainers) • Conduct trainings and orientations for high-level officials • Engage in quality assurance (e.g., verify provider knowledge using KIT) • Help local staff develop training plan • Build relationships with pre-service institutions
Dissemination and Advocacy	• Ensure that scale-up remained a MOH and partner FP priority • Orient/educate new MOH staff and donors on scale-up • Provide technical input and review to communications projects • Provide oversight and funding to social marketing initiatives • Spearhead innovative communications strategies • Advocate for SDM inclusion in multi-method communications campaigns
Cost/resource mobilization	• Advocate for MOH and donor funding to support scale-up • Identify opportunities to leverage available resources • Facilitate relationships for CycleBeads procurement • Advocate for CycleBeads inclusion in donor and/or MOH budgets • Donate CycleBeads where alternative funding is not available
M&E	• Ensure MOH has mechanism for tracking service statistics • Analyze service statistics • Conduct periodic surveys of providers, community health workers, users • Identify needed improvements based on data

Bilateral projects and NGO networks greatly facilitated geographic expansion, but had drawbacks. Scale-up in Mali, Rwanda, DRC, and Guatemala relied heavily on resource organizations other than MOH to do the work of horizontal scale-up. Bilateral health projects in these countries were important resources that provided training and technical assistance for geographic expansion. A willing bilateral partner could do the job of geographic expansion, do it well and do it at scale. For example, the USAID-funded *Projet Keneya Ciwara* (PKC) in Mali successfully introduced SDM in its intervention districts in Bamako and seven of the country's eight regions. IRH, as the bilateral's resource organization, measured a large geographical impact as a result of this partnership, with a comparatively low outlay of its own resources.

But relying on bilaterals also had drawbacks. First, they did not cover 100% of any of the scale-up countries; other areas were covered by other partners or not at all. In Rwanda, for example, bilaterals reached two-thirds of the country while UNFPA covered the remainder and did not have the capacity to carry out the work of scale-up. Second, bilateral projects were time-bound entities and thus did not often mesh with sustainability goals. No bilateral was in place in Rwanda from 2010-2012, and the uncertainty during that gap made planning for SDM sustainability a challenge. Reliance upon donor-funded, short-term

projects in general raised the question of long-term SDM sustainability in Rwanda. Table 12 identifies some of the advantages and disadvantages of working with bilateral projects.

Table 12: Advantages and Disadvantages of Working with Bilateral Projects

Advantages	Disadvantages
Bilateral Projects…	
• provide greater staffing for scale-up • bring technical expertise and the ability to do the job well • provide enhanced geographic coverage • come with their own funding	• are by nature temporary, making sustainability uncertain • rarely cover an entire country, leaving gaps • mean that IRH had less direct oversight of scale-up process, with implications for quality assurance

In DRC, although a bilateral was in place, much of the state health system was supported by a mosaic of NGOs and FBOs. IRH and MOH started with a small group of partners as a resource team, and later formed strategic partnerships with NGOs and FBOs to expand to more health zones. In Guatemala, NGO networks, in addition to the MOH, served as resource organizations. IRH also worked directly with APROFAM, a large IPPF affiliate, as both a resource and a user organization.

In Jharkhand, by contrast, IRH worked directly with the MOHFW to strengthen systems and build provider capacity at every level, and did not use non-MOH resource organizations to the extent done in other countries. The reasons for this were (a) no bilaterals were working in most districts where the state government wanted SDM to be scaled up, and (b) no NGO networks with sufficient technical and financial resources existed. An advantage of working directly with the MOHFW was that it learned to serve as its own resource organization. This favored sustainability, and assured IRH more control over quality and process than it had in other countries. On the other hand, because there was no 'middleman' resource organization in India, IRH needed a larger presence on the ground. Limited resources meant that IRH had the staff capacity to facilitate scale-up in only half of Jharkhand state, whereas the government wished to scale-up in the entire state.

Many user organizations, especially the MOH, had relatively weak capacity to support a scale-up process; a health systems strengthening approach was thus required.
In all countries, the primary user organization was the government health program (and, in Guatemala, the social security institute), which generally lacked the infrastructure, expertise, and human resources to conduct the work of scale-up. Consequently, significant technical assistance in capacity building, quality assurance, supplies, monitoring, and supervision was required. In Rwanda, Mali and DRC, CAs provided support to FP services, and the stability of the scale-up effort depended on the stability and commitment of those organizations. In Jharkhand, no CAs managed FP projects in large geographical areas, so it was particularly important to incorporate a health systems strengthening component to scale-up.

In sum, factors that enhanced the success of the resource team included MOH leaders who actively supported scale-up, and a mechanism (task force, resource team) that met regularly to coordinate the process. The role of an organization such as IRH was crucial: IRH served as a resource for other resource

organizations and provided oversight to scale-up as a whole. Resource organizations with a stable source of funding were able to work with a consistently high level of effort during the scale-up phase, and so were poised to promote sustainability in the longer term.

3.3.5 The Innovation

The innovation is at the heart of any scale-up effort, yet the presence of the innovation alone—in this case, SDM and the accompanying CycleBeads tool—is insufficient for successful scale-up. An *innovation package* must be developed, including all items and even concepts that support the innovations expansion and institutionalization. This section discusses how IRH and partners defined the SDM innovation, how components of the package evolved, and how resource teams ensured that the innovation remained effective even as the package changed over time

Defining the innovation at the beginning of the scale-up phase facilitated strategic planning.

During the launch meetings in most scale-up countries, stakeholders were introduced to the ExpandNet framework by ExpandNet experts, who then guided participants to define the SDM innovation. In all countries, CycleBeads were naturally at the center of the innovation package, but it also included training modules, quality assurance and monitoring tools, provider counseling aids, and outreach materials. Figure 11 graphically represents the components of a typical SDM innovation package.

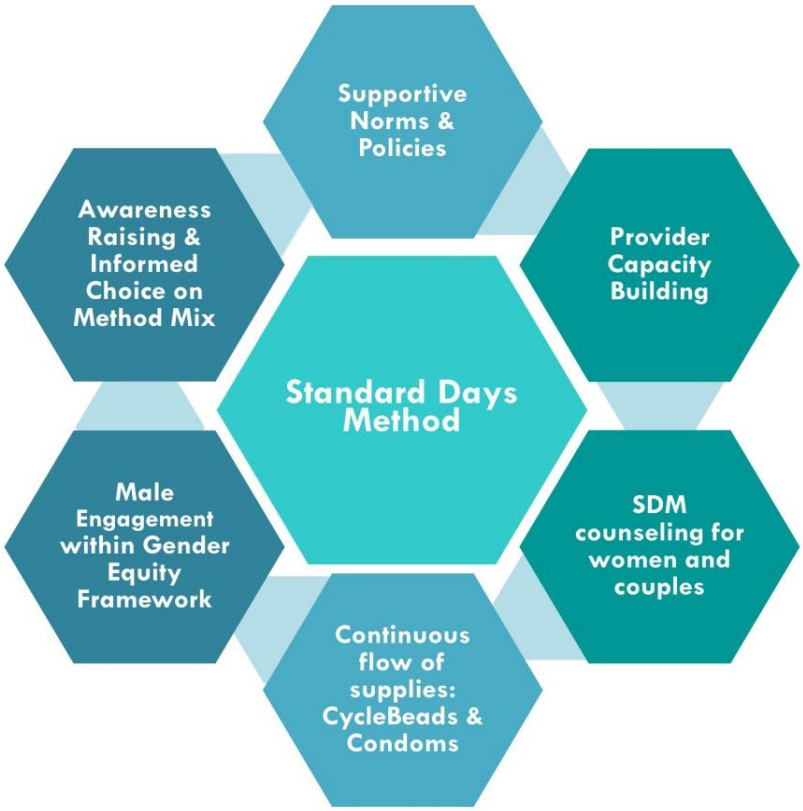


Figure 11: Components of the SDM innovation package

Simplification of the innovation was required to meet the needs of the scale-up countries' systems.

Almost all elements of the innovation package that had been developed prior to the SDM scale-up phase were revised, often at the request of user organizations (the MOH or NGOs). Common to all countries was the need to simplify and adapt elements of the package to meet the needs of system into which SDM was being integrated. Several of the most important adaptations are described here; see Appendix E for additional information.

- *Shorter training times*: To accommodate integration of SDM training into national FP curricula, and to meet the demands of training of large numbers of health care providers, it was necessary to reduce training times in all countries. In DRC the reduction was particularly dramatic, from a comprehensive

FP training of five days, which IRH used during the introductory phase, to a streamlined SDM training of three to four hours.

- *Adaptations for community health workers*: IRH's operations research found that the quality of services offered by community health workers was similar to that of facility-based providers, and that community health workers could be an important channel to expand SDM access.[50] Therefore, all countries modified the innovation by incorporating a community-based strategy designed for the local context, with training modules targeted to non-clinic providers, such as community health workers, ASHAs, and/or and traditional midwives. Counseling aids were also modified; the comic book created in India was an especially successful addition to the innovation package.

> "When I think of the way the innovation has changed, I think that we have really streamlined SDM. We have figured out ways to…reduce the package that is the innovation to something that's more do-able."
>
> - IRH Staff Member, 2011

- *Improved user instructions:* Resource teams adapted client materials to make them more user-friendly. CycleBeads instructions were translated into Kinyarwanda (in Rwanda), for example, and into the major languages of DRC. India's instructions were adapted to include more pictures for greater comprehension by low-literacy users. In Mali, a special effort was made to sell CycleBeads at local shops, and instructions were modified to serve clients who obtained CycleBeads without the aid of a health care provider or community health worker.

The innovation package's tools and materials retained SDM's core values even as they were simplified and improved.

> During the trainings, we cover a lot of other themes, like gender and sexuality. These are important pieces that weren't included before. Now the trainers and trainees get the whole picture and understand how SDM (or any method) can fit into the strategies of the country. It's a value-added service that we provide.
>
> - IRH Country Representative, Guatemala

Stakeholders at the launch meetings in each country learned of the need to track the innovation's *core values* as it went to scale. When developing and introducing SDM, IRH explicitly assigned to the method the core values of *equity of access*, *male involvement* and *informed choice*. Stakeholders designated these core values an element of the innovation package in each country.

As SDM was mainstreamed into FP programs, IRH and partners ensured that all materials and activities positioned SDM as one of a basket of FP options, and offered information on all available methods. In India, for example, IEC such as murals, posters, and community radio programs portrayed not only SDM, but the entire range of methods available, even while donor-funded campaigns for other methods did not take this approach. As the innovation was simplified, it maintained a strong focus on men, and on gender and sexuality issues that could constrain or facilitate effective FP use. For example, a component on gender was added to trainings in Guatemala, and promotional messages such as 'Talk with your partner,' and 'Decide together how you will handle the white

[50] Gribble, J.N., Lundgren, R., Velasquez, C., Anastasi, E. 2008. "Being strategic about contraceptive introduction: the experience of the Standard Days Method." *Contraception*: 77(3) 147-154.

bead days' emphasized the couple. Some outreach activities specifically targeted men. Chapter 3.5 discusses core values further.

Simplified tools and materials were evaluated to ascertain that service quality and correct use were not compromised.

Changes to elements of the innovation package were field tested and evaluated on a small scale before being integrated into scale-up work. To note several examples, new or revised training curricula were pre-tested prior to widespread use; a shortened KIT was validated as a quality assurance tool during supervision at scale; and the simplified client screening protocol to reduce medical barriers to SDM use was evaluated in India (and Ecuador, via a separate IRH program) to ensure that effectiveness was not compromised.[51]

In sum, the innovation was not simply SDM or CycleBeads, but rather a package of tailored elements required for successful integration of SDM into health services systems, including recognition of the innovation's core values. A participatory, multi-organizational process to define the innovation package helped ensure that stakeholders would not focus exclusively on product availability and training, which are necessary but insufficient for scale-up. All elements of the innovation package required adjustment to fit the unique contexts of each country; some modifications were global such as revision to the screening protocol. IRH and partners field-tested and evaluated each adaptation prior to widespread use, to ensure it did not reduce effectiveness. The ExpandNet framework was a useful guide to a participatory and evidence-based process for defining and redefining the innovation package.

3.4 How Was Scale-Up Achieved? Tasks, Functions and Activities

3.4.1 Overview

The systems elements described in the preceding section were the foundation for the scale-up strategy that IRH and partners developed in each country. The strategies were further defined by reasoned, context-specific choices in what the ExpandNet framework calls *strategic choice areas.* These choice areas, and the functions and activities that flowed from them, are the topic of the present section. This section describes the many functions and tasks that comprised the process of scaling up SDM, both horizontally and vertically. While global commonalities did exist, the specific tasks undertaken, the extent of each activity, the methodologies used, and the actors involved, were tailored to the needs and opportunities within each country and to the changing contexts over the course of the scale-up phase.

3.4.2 Monitoring and Evaluation

> "We could not function without data. We review data monthly and make decisions."
>
> - Jharkhand stakeholder

Just as scale-up as a whole was guided by the systems approach represented in the ExpandNet framework, so was M&E of scale-up. The data sources that IRH used to document and understand the scale-up process (defined in Chapter 2.2.3) were also used to monitor and guide it, and to evaluate the outcome (Table 13). A strategic approach to M&E contributed to the success of SDM scale-up, by providing snapshots of

[51] Institute for Reproductive Health, Georgetown University for the United States Agency for International Development. *Cycle Length Screening*. November 2010. Washington, D.C.

progress that kept stakeholders focused and engaged and allowing for evidence-informed, mid-course corrections.

Each country assembled an M&E team at the start of the scale-up phase, which included the IRH Country Representative and two IRH staff in Washington, DC: the M&E coordinator and country-specific research back-stop. In Guatemala and India, IRH also hired dedicated M&E experts. Elsewhere, local consultants collected information and DC staff supported data analysis. This had some disadvantages, but was a functional option in resource-constrained settings.

Table 13: Tools Used to Track Various Aspects of Scale-Up

Tools/Approaches Used ↓ to Monitor →	Coverage	Sustainability	Process	Quality	Values
Household Survey	■	■			
SDP Survey	■	■			
Provider Interviews				■	■
Benchmark Reporting	■	■	■		
Service Statistics (and sales, stock-out reports)	■	■	■		
Key Events Timeline		■	■		
KIT and CFU				■	
Stakeholder Interviews		■	■		■
Focus Group Discussions with IRH staff		■	■		■
MSC Story Collection			■	■	■

Quantitative tools. IRH first identified the process and goals of SDM scale-up, then selected simple, measurable indicators to track progress along both the horizontal (geographic expansion) and vertical (institutionalization) axes. IRH developed a database in Microsoft Access to standardize data entry and centralize data collection. For each indicator, country teams developed numeric **performance benchmarks** that could realistically be achieved within five years. Countries reported against the benchmarks twice annually. At the end of the first year of scale-up, country teams assessed the benchmark targets and adjusted them as needed. The benchmarks were not adjusted further.

In the SDM introductory phase, IRH developed several **quality assurance tools** to assess provider competence and client knowledge/use of SDM. During the scale-up phase, these monitoring tools—the KIT and CFU—were used in varying ways in each country, and the resulting data helped IRH and stakeholders assess the overall quality of provider training and counseling.

Several other quantitative tools were used to evaluate horizontal scale-up and these focused on quality and availability of services and demand for services. **Household surveys** with women and men measured knowledge, attitudes and use of FP methods, and revealed the position of SDM relative to other methods. Also assessed were gender attitudes, exposure to SDM IEC messages, social diffusion of SDM, and knowledge of sources for CycleBeads. **SDP surveys**, which encompassed facility assessments and provider interviews, examined readiness and capacity to offer SDM services, and measured attitudes and competence among facility- and community-based providers.

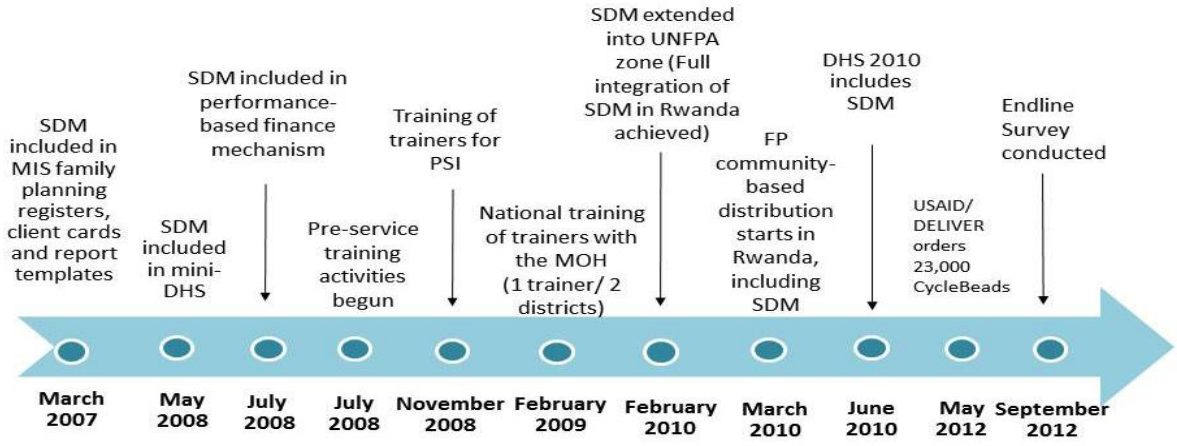
While most M&E elements were implemented in all countries, the budget did not allow for large scale baseline, midline, and endline surveys of households *and* SDPs in all five countries. Therefore, IRH prioritized activities and decided which M&E elements would be most useful and with what timing. These decisions were made in consultation with stakeholders and USAID and depended on the country context, the stage and process of scale-up, and cost of each element. Table 14 shows which quantitative elements were conducted in each country and when. Baseline data collection took place in the second year of the scale-up phase (the first year was devoted primarily to strategic planning); midline in the third; and endline in the final year.

Table 14: Quantitative Tools and Frequency, By Country

Research Tool	DRC	Guatemala	India	Mali	Rwanda
Household survey	Endline	Baseline Endline	Baseline Endline	Baseline	Endline
SDP Survey including facility-based provider interviews	Midline	Baseline Endline	Baseline Endline	Baseline	Baseline
Community-based provider interviews	-	Baseline Endline	Baseline Endline	Baseline	Endline

Qualitative tools. Three qualitative methodologies were used to evaluate SDM scale-up. First, **stakeholder interviews** were conducted in all five countries at baseline and endline to ascertain the attitudes of key FP actors and to identify factors that constrained and facilitated scale-up. Interview results at baseline helped shape the adaptation of the innovation package to each country context. Interview results at endline were important for evaluating the outcome of scale-up from the program, provider, and SDM user perspectives. Second, **MSC story collection** asked scale-up partners to solicit stories from users, providers, and program managers to determine how they valued SDM and its integration. MSC also allowed IRH to identify unanticipated consequences of SDM scale-up. Third, recognizing that myriad factors could influence the operating environment in each country, IRH staff tracked key events to help monitor external forces and their effect on scale-up progress. As an example, Figure 12 shows Rwanda's **key event timeline** from the first years of scale-up.

Figure 12: Rwanda's Key Event Timeline, 2007-2012



Other data sources. IRH used secondary data whenever available, including DHS, Service Provision Assessments (SPAs),[52] and service statistics collected by the MOH. IRH also undertook special studies to respond to new questions and evolving opportunities. For example, toward the end of scale-up, IRH tested several social diffusion approaches to increase SDM and FP awareness and create demand in Guatemala, Mali, and Rwanda.

Use of data for decision-making and quality improvement. IRH shared study results and other data with the MOH and other stakeholders and used the information to improve scale-up work with policy makers, managers, and technicians. India and Guatemala especially reported using district data (service statistics, benchmark indicator achievements, and to some extent baseline/midline survey data) to determine what was working well and what needed attention. All data-driven modifications to scale-up activities were decided in a participatory manner. For example, IRH in India collected district- and block-level statistics monthly, analyzed and graphed them, then met with district program managers and medical staff to discuss and explore reasons for positive and negative outcomes. Together they identified and addressed problems in training, stock-outs, record keeping, and service quality.

Baseline data collected for evaluation purposes were also used to identify gaps in the extent and quality of SDM services and community knowledge of SDM, as were data from secondary sources. In Rwanda, for example, benchmark indicators showed good progress toward targets, but a government facility survey suggested that troubled supply chain mechanisms were causing facility level stock-outs. The resource team undertook concerted efforts to resolve the problem.

Not all data sources were exploited to the same extent. IRH country staff, partners, and stakeholders found the benchmark-monitoring data and the quality-assurance data more useful, for example, than the key event timeline. Yet all data elements complemented one another, and together provided a complete picture of progress. Overall, M&E data were used to: (1) assess adaptation of the innovation package; (2) guide strategic planning; (3) identify and monitor resolution of problems; (4) maintain stakeholder commitment to the scale-up process; and (5) involve new partners in scale-up. Care was taken to share data with stakeholders at least annually, and more frequently if problems were identified that needed immediate attention.

3.4.3 Building Health Worker Capacity

An important focus of the FAM Project was to develop the capacity of health workers at many levels to offer SDM. The aim of sustainable scale-up drove IRH's capacity-building strategy, which:

- Incorporated SDM training into existing capacity-building systems, both pre-service and in-service,
- Implemented training approaches for large numbers of providers, from facility to community levels, and
- Ensured quality services through ongoing supervision

During the introductory phase that preceded SDM scale-up, IRH developed materials, curricula, and job aids for several levels of providers; conducted provider training; and developed and implemented tools to

[52] Both DHS and SPA are conducted under the umbrella of Measure DHS/ICF International. http://www.measuredhs.com/.

measure and reinforce post-training provider capacity. During scale-up, IRH adapted these materials to achieve both vertical and horizontal scale-up goals. At the close of the SDM scale-up phase, capacity for SDM training in the five countries lay within public sector agencies, academic institutions, NGOs and private sector organizations. The many training resources developed, tested and used with local counterparts were widely disseminated within each country and globally; the compendium of resources is now available in the Knowledge for Health Toolkits[53] electronic collection.

Incorporating SDM training into pre-service education

In all five countries, SDM was integrated into pre-service nursing, paramedical and medical school education. The extent of activity and success was particularly determined by whether integration was targeted at national curricula or took place sub-nationally.

In Guatemala, SDM was integrated into all 52 nursing assistant programs and the national professional nursing program in 2007. With the onset of scale-up, IRH therefore focused efforts to strengthen faculty skills by providing contraceptive technology updates and supported service providers by developing two SDM continuing education courses. The latter were distance-learning self-study that could be administered on paper or electronically and contributed to broader diffusion of SDM knowledge and skills at lower cost. Moreover, they contributed to sustainability as the courses were installed in the MOH workforce training program.

In the three African scale-up countries, SDM integration in pre-service curricula began in the introductory phase and was completed during the scale-up phase. In DRC, the basic nursing training curriculum incorporated a fully updated course on FP methods, including SDM, and teacher training; IRH contributed heavily to these. In Mali, IRH successfully advocated that the MOH, with support from USAID, complete and launch a new FP curriculum, including SDM, in 2011. In the following year, the MOH funded the dissemination of the curriculum and the training of preceptors in 16 schools. SDM was fully integrated into Rwanda's nursing pre-service education in 2008 as part of the development of a national FP curriculum to support nursing school reform.

In India, SDM integration into pre-service curricula began in late 2010. IRH assessed conditions for integrating SDM into medical and nursing pre-service education in India, then used the findings to guide planning and implementation, and to determine how to mobilize key players to facilitate the integration process. By 2013, a handful of nursing schools in Delhi participated in a FP workshop in which IRH introduced SDM and materials to help faculty integrate the topic of SDM into existing syllabi.

Adapting curricula for training large numbers of providers

An important aspect of the SDM innovation in all countries was to streamline training to accommodate the method's integration into existing FP curricula: it was necessary to train large numbers of providers operating in different service delivery contexts and FP programs in shorter periods of time. Equally important, each time significant changes were made, IRH validated the effectiveness of the materials in building provider competency, using the KIT to assess provider competency during a simulated role play as

[53] K4Health and United States Agency for International Development. *Toolkits by K4Health.* http://www.k4health.org/toolkits/SDM. Accessed September 2013.

well as other measures. DRC offers a useful illustration: there, IRH integrated SDM into revised FP curricula, both pre- and in-service, for health workers in the public system including secondary-level nurses and community-based health workers. SDM also was incorporated into the training of specialized workers, such as pharmacists and FBO counselors, and was linked to social marketing projects. Numerous bilateral projects, FBOs, NGOs (national and international), and government bodies all integrated SDM into their FP trainings; training time ranged from two hours to one day. With MOH and IRH assistance, the FBO, *Conduite de la Fécondité,* developed and tested an integrated module for training providers in natural FP methods, including SDM.

IRH used such opportunities to integrate SDM into training and reaffirm the method's core values. In Guatemala, for example, SDM was positioned as a couples-method in a context where male involvement was deemed critical. IRH-led training incorporated cross-cutting topics such as gender, sexual and reproductive rights, sexuality, and partner communication.

Incorporating SDM into in-service education

In-service training of health workers was central to expanding SDM service availability. In all five countries, IRH conducted trainings of trainers to establish a cadre of qualified facilitators for SDM training; master SDM trainers, in the traditional sense, were not commonly available. FP personnel vested with this responsibility routinely delivered training and refresher training, initially with IRH supervision and independently thereafter. In-service training reached medical personnel (doctors, nurses, auxiliary nurses), community health workers and service staff. Of course, the frequency of trainings, the affiliation of trainers, and the levels (national, district) at which trainings took place varied by country.

While SDM became an official component of in-service FP curricula in all countries, in-service training is not routinely delivered in many MOH programs. Where routine training was lacking, IRH funded trainings that MOH staff conducted, covering all methods and emphasizing SDM as a new option. The balance between provision of SDM training by IRH staff, and SDM training by user/resource organization staff, varied over time. India relied on trained MOHFW staff to conduct contraceptive technology updates that included SDM. This in-service training was paid for by the government of Jharkhand and delivered by district personnel with IRH oversight. In Rwanda, training organized by MOH and partners relied on varying levels of IRH technical support, depending upon the user organization's capacity. In the second year of scale-up, partners trained by IRH became increasingly responsible for conducting cascade training for their staff. In Guatemala, MOH medical personnel trained district nurses who in turn trained traditional birth attendants. IRH co-funded and coordinated these trainings.

While training was based on cascade training approaches in all countries, several opportunities arose to expand SDM training through task-sharing. In Guatemala, India, and Rwanda, task-sharing contributed to scaling up SDM service delivery, thus expanding training for new cadres of personnel working beyond the facilities. Rather than bring experienced training professionals from New Delhi, IRH staff in Jharkhand trained local providers as trainers in a deliberate effort to build sustainable capacity in the state. In Rwanda, IRH staff supported capacity building of the national FP program by assisting with the pilot and roll-out of Community Based Provision of FP, a new component of the MOH's FP program that began mid-way through the scale-up phase.

Effectiveness of trainings

Evaluation of the effectiveness of cascade-based training during the scale-up phase required regular monitoring. Evaluation of SDM trainings included pre- and post-tests, trainer feedback, and on-the-job competency assessments (KIT) during supervision. The KIT was applied within three months of a training event and was used periodically to determine quality of service delivery over time. The KIT allowed supervisors to quickly identify knowledge gaps and provide targeted support during routine supervisory visits.

Refresher training, which was common in all five countries, was a further opportunity to observe trainers and offer support and feedback. Refresher trainings in DRC were scheduled as needed, based on KIT results. Refresher training tended to be informal in Guatemala: reinforcement typically took place during supervision and KIT application. In Mali, regularly-scheduled SDM refresher training was incorporated into bilateral-supported FP refresher training. IRH and partners also measured trainings' effects on service provision by analyzing service statistics and administering the CFU.

Because the KIT was used in all five countries, IRH could compare competency across settings, regardless of variables such as type of trainer, training tools used, or length of workshop. Aggregate results from Guatemala, India, and Rwanda are presented in Table 15. KIT data was collected regularly throughout the scale-up phase in India and Rwanda, and in 2010 and 2011 in Guatemala.

Table 15: KIT Results on Provider Competency in SDM during Counseling in Rwanda (2008-2012), Guatemala (2010-2011), India (2008-2013)

	Community Health Worker	Auxiliary Nurse	Professional Nurse/Midwife	Doctor	Total
n=	606	1092	77	64	1839
Counseling Points					
Demonstrated correct use of CycleBeads	76.8%	94.5%	88.2%	80.4%	87.9%
SDM screening criteria					
Screened for cycle length within range	90.3%	88.8%	93.4%	71.9%	89.1%
Screened for client and partner ability to abstain on fertile days	45.0%	66.9%	67.1%	64.1%	59.9%
Cycle length monitoring					
Short: period starts before dark bead	N/A	63.6%	85.5%	45.3%	67.5%
Long: period does not start day after last bead	N/A	67.9%	87.5%	45.3%	66.2%

The data in Table 15 show overall a moderate level of competence (IRH uses a competency threshold of 75%). SDM knowledge and skills were consistently higher among nurses than doctors or community health workers. SDM counseling involves both screening for method eligibility and teaching/counseling clients on how to use the method. Ability to teach clients how to use SDM with CycleBeads is high across level of

providers (87.9%) especially among front-line providers such as auxiliary nurses who tend to provide the most FP counseling and use this skill regularly. All providers generally screen for cycle length criterion (89.1%), but fewer screened for the behavioral criterion related to the client's ability to abstain or use condoms during fertile days (59.9%). SDM counseling explicitly addresses partner communication and sexuality issues. These are sensitive topics that providers in general may not feel equipped to address and deal with these only superficially. Providers lack overall counseling skills, experience and time to deal with difficult issues, in particular clinicians who are more likely to prescribe a method than explore options with clients. In the case of CHWs, the majority of data comes from India (84%), where SDM has been incorporated into ASHA training in a brief 4-hour segment. This aspect of screening remains a challenge to be addressed in training given programs reality of integrating SDM into existing contraceptive technology updates that are brief and less frequent.

Resources for sustainability of institutional capacity

IRH developed several generic resources that resource and user organizations could use to create and maintain local capacity. Based on more than a decade of work to introduce and scale-up SDM, these resources included tools for:

- equipping faculty in pre-service medical training institutions (faculty module and pre-service guidelines);
- delivering SDM through continuing education (self-study course and online course);
- training service providers (Family Planning Provider Manual, Community Health Worker Training Manual); and
- FBO-appropriate training tools.

IRH also developed an SDM module for program managers for USAID's Global Health eLearning Center. These items served as references when planning and implementing trainings in the five countries, and remain freely available in the scale-up countries (and elsewhere).

Organizations in the five scale-up countries also developed an array of training tools and instruments, following collaboration with and technical assistance from IRH. These included an online training course and a self-study course for healthcare professionals in Guatemala, a self-study course, storyboards and materials produced in the form of a comic book for use by ASHAs in India, and an illustrated job aid for traditional birth attendants in Guatemala. These were targeted to a range of users, from faculty at nursing and technical schools, to master trainers, to service delivery personnel in facilities and communities, to non-medical development workers. While some of these tools were SDM-specific, most were comprehensive presentations of FP methods and reproductive health topics.

3.4.4 Advocacy

An essential element of a systems approach to scaling-up health innovations is advocacy to fully establish the innovation in policies, programs and service delivery. During SDM scale-up, advocacy was crucial to gaining stakeholder buy-in of SDM integration into the many components of a national (or sub-national) health system. This section highlights how IRH and partners used advocacy as an effective tool for scale-up.

Advocacy focused on integration of SDM at all levels, and on implementation of scale-up activities

IRH's primary advocacy goal in all countries was SDM's integration into national (or state, in India) FP policies, systems and programs, including:

- FP guidelines and protocols (in most countries, SDM had already been integrated into norms)
- HMIS
- IEC materials and campaigns
- Budgets
- Training agendas, schedules and curricula (in-service and pre-service)
- Procurement plans
- Logistics systems
- Operational/implementation plans
- M&E, including national surveys

Other vital advocacy goals pertained to the management and execution of scale-up activities, such as:

- Briefing incoming MOH leaders to gain their support, particularly in Guatemala and India where leadership changed frequently
- Securing written commitment to scale-up, such as from the Government of Jharkhand
- Ensuring that MOH and other leaders followed through on their commitments to scale-up
- Obtaining buy-in from providers and staff who would implement policies and services

Advocacy also was directed towards organizations that did not provide FP services but could serve other important functions (e.g. social marketing and pre-service training) to solicit their participation in scale-up.

Stakeholders' information needs and advocacy channels

Advocacy was tailored to the contexts and stakeholders in the five scale-up countries. Table 16 summarizes the main types of stakeholders to whom advocacy was directed, the types of information that stakeholders needed, and advocacy channels that IRH used to reach them.

Table 16: Types of Stakeholders, Information Needs and Advocacy Channels Used

Stakeholders	Information needs	Advocacy Channels
• MOH leaders and other government officials • USAID-funded FP technical assistance projects • INGOs/NGOs/FBOs involved in FP services • Social marketing organizations • Private sector FP services • Organizations that could provide critical support functions, such as pre-service training and distributing CycleBeads	• Value of adding of SDM to FP programs • Evidence to support SDM integration • Program results, including M&E data • Action plans • Sustainability or profitability of SDM	*Personal*: • One-on-one meetings • Networking • Team / task force / coalition meetings • Presentations • Orientation meetings • Trainings *Print/media*: • Fact sheets / policy briefs • Scientific articles • News and newsletter articles • Websites

Relationship building and personal communications were the foundation for advocacy.
Personal communications were more effective than impersonal, although both were necessary. Specifically, building relationships with key individuals was essential to laying the foundation for collaboration, establishing open lines of communication, and fostering trust. In Guatemala and Jharkhand, MOH leaders changed every year or two, so IRH met with new officials to brief them and secure their support. Also in Jharkhand, IRH held orientations and trainings for top-ranking government staff such as medical officers so that they could engage in and support the scale-up effort.

IRH's involvement in each country's FP community provided vital advocacy opportunities: IRH not only had a seat at the table when FP decisions were made, but could demonstrate its leadership capacity and win respect and trust. In Rwanda, for example, the IRH Country Representative served on the MOH's MCH and FP task forces, where she contributed to the important decisions made by these influential bodies. In DRC, IRH's extensive contributions to planning a major FP conference influenced decision-makers about the importance of including SDM in the national FP program. In Guatemala, IRH participated in the National Commission on Contraceptive Security, enabling it to represent SDM in discussions on the Law on Universal and Equal Access to Family Planning services, which in turn influenced procurement decisions (albeit ones that were not acted upon due to UNFPA's internal decisions).

> "It will be important to show data to the Permanent Secretary and the Minister – how many people initiate, how many continue, age-parity, how it contributes to reducing the total fertility rate."
>
> - Partner in India

As important as it was to engage high-level decision makers, it was also strategic to work with community-based organizations. For example, mayors of several Malian communes participated in trainings held by women's savings associations. In Guatemala, the Indigenous Peoples' Healthcare and Intercultural Unit was a member of the resource team and engaged its constituency in SDM scale-up. Leaders of faith-based networks (Muslim and Catholic) in DRC were key advocates. Affiliating with important community actors not only ensured that their voices were heard in the scale-up process, but demonstrated to policy makers that there was grassroots support and demand for the method.

Advocacy required country-specific data and messaging.
Organizations needed tailored information about how SDM would benefit their work and the clients they served. While global studies and WHO guidance documents were useful, it was more compelling to demonstrate how integrating SDM would contribute to reaching national or organizational FP goals. Country-specific research results and M&E data that showed the actual or potential impact of SDM integration were important. Results from research conducted during the SDM introduction phase in India and Rwanda, for example, showed that SDM attracted new FP users. IRH shared this type of information at meetings and presentations. For private sector organizations such as APROFAM, which became the CycleBeads distributor in Guatemala, IRH included context-specific discussion of the financial sustainability and profitability of SDM services.

In all countries, SDM was positioned initially within the context of FP and reproductive health priorities, an informed choice framework, and as a method that would help reduce unmet need for FP. This was followed

by more nuanced positioning in each country. In Rwanda, for example, a government and donor shift toward LARC prompted IRH to position SDM as a long-term option for many users. It was also carefully situated within the range of methods to avoid the appearance that SDM was suitable only for FBOs. By contrast, advocacy messages in Mali included an explanation of SDM's compatibility with Islamic doctrine. In India, SDM integration was cast as a way to strengthen birth spacing programs, which had suffered from years of emphasis on permanent methods.

Maintaining a positive reputation and fostering a sense of ownership among user and resource organizations were indirect yet effective advocacy strategies.

If scale-up were to succeed, IRH had to establish its own credibility in each country. IRH gained a certain degree of legitimacy by providing technical assistance on SDM integration, but broader and more intense efforts were required. In Rwanda the Country Representative's service on several health committees earned IRH a solid reputation as an innovative, experienced, and politically neutral agency. IRH was invited to important FP-related meetings and increased its opportunities for advocacy. In Jharkhand, IRH's hard work in rural districts where other technical assistance agencies would not travel demonstrated to the MOHFW that it was an indispensable partner.

Another indirect advocacy strategy was to foster a sense of ownership in scale-up among resource and user organizations. The government of Jharkhand chose the districts in which SDM should be scaled up, and it was the MOHFW, not IRH, that hosted partner meetings. In Guatemala, IRH provided an array of opportunities for partners' involvement: participation on the resource team was one opportunity, and others were presenting at workshops on FP policies, and facilitating linkages between indigenous communities and health systems.

Advocacy beyond the public health sector engaged diverse groups and promoted social diffusion.

Advocacy for SDM took place at all levels of the public health sector in each country (national, regional, district, community) to foster simultaneous vertical and horizontal scale-up. But advocacy did not end with the public health sector. IRH and partners advocated for SDM integration with religious groups in Mali, Rwanda, DRC, and Guatemala. They engaged civil society groups that worked for sexual, reproductive, and women's rights in Guatemala, Mali, and Rwanda. Advocacy with such groups had the further benefit of spreading the word about SDM.

Champions facilitated scale-up, though the long-term effect was uncertain.

SDM 'champions' arose in all countries, but their effectiveness varied with levels of commitment, influence, and the amount of time they could devote to scale-up (Table 17). One important role that champions tended to play was to facilitate the participation of organizations that IRH might not otherwise have been able to reach. In DRC, for example, IRH benefited from the championship of *Conduite de la Fécondité*, a Catholic FBO, that invited and encouraged other FBOs to integrate and promote SDM in their service work. *Conduite de la Fécondité* and the Muslim FBO, *Mamans An'sar,* also convinced religious leaders to accept and advocate for SDM and to refer couples and women to FP services. An individual champion in Mali—the leader of a women's association—worked not with decision-makers or leaders but at the user level, where she promoted social diffusion of SDM.

Table 17: A Summary of Type of SDM Champion By Country

Type of Champion	DRC	Guatemala	India	Mali	Rwanda
MOH officials					
FBO representatives					
Local NGO representatives					
International NGO representatives					
USAID bilateral project representative					
Social Security Institute staff					
Women's association leaders					

While fostering champions is often viewed as a way to promote sustainability, IRH's experience in SDM scale-up was that most champions moved to other positions or organizations that did not provide them the opportunity to continue advocating for FP.

In sum, advocacy was an essential component of the SDM scale-up phase: it was needed to firmly integrate the innovation into policies and systems. Advocacy approaches were implemented on a foundation of strong interpersonal relationships with key stakeholders, and the solid reputation that IRH developed as the scale-up resource organization. Advocacy messages were tailored to country contexts to meet the needs of policy makers and influencers, and attention was paid to best positioning SDM within those contexts. Where possible, IRH found opportunities to foster a sense of ownership among the user/resource organizations. Finally, champions helped bring new organizations into the scale-up process and expanded the reach and impact of advocacy messages.

3.4.5 Dissemination/Diffusion and Demand Creation

Demand creation is an integral component of scaling up any new FP method within a service delivery system. Demand creation strategies encompass the array of efforts made to raise awareness and foster interest among potential users, who must be aware that a method exists and know at least some of its attributes before thinking about using it. Strategies can be designed to provoke new ideas, discussions and practices among trusted peers. A demand creation strategy can help not only to diffuse new information, but to change attitudes and behaviors; it can help solidify a method's 'social reputation.'

Scale-up required refocusing the reach of and segmenting audiences for awareness-raising and demand creation.

This included shifts in target audiences, segmentation, messages, and approaches (Table 18). Prior to SDM scale-up, the purpose of informational products was to support introduction in relatively small geographic areas. Print materials such as brochures and posters, most created by IRH, raised awareness of SDM and CycleBeads with potential clients in clinics and the zones they served. The purpose of these materials and the scope in which they were used changed during the scale-up phase, and market segmentation helped tailor messages to sub-groups such as men. And because IRH did not have the funds to support the needed level of demand creation, it was paramount to form partnerships and take advantage of low-cost opportunities to raise awareness of SDM.

Table 18: Changing Objectives of Demand Creation Strategies

Element of Demand Creation Strategies…	Introductory Phase Objectives		Scale-Up Phase Objectives
Information Targets	Clients use SDM correctly, supported by client counseling and focused awareness raising	→	SDM and its attributes are as well-known as other methods within communities
Audience Segmentation	Communities reached by introduction/research efforts	→	Women/men; public/private/FBO sector consumers
Message Focus	Promotion of new method and asking interested clients to seek services	→	Same plus segmentation: reaching new sectors and addressing relevant issues such as reproductive rights and engaging men
Typical Approaches	Print materials, posters, education talks	→	Radio & TV, community mobilization & social diffusion, edu-tainment with broader reach

Content was tailored for country contexts while maintaining core messages.
Core messages were that a new method of FP was available and where, and the characteristics that distinguished SDM from other options: ease of use, economies of a one-time purchase, natural modern option with no side effects, opportunity to increase understanding of one's fertility, and engaging men. All materials included messages that positioned SDM as one option among a variety of choices.

An analysis of themes that were important in each country guided message building. For example, Guatemala emphasized that SDM was a modern method, while India focused on SDM as a method for couples to use together. Meanwhile, in DRC and Rwanda, messages for new users positioned SDM as a method that would suit certain groups that had not previously used FP, including audiences in faith-based communities.

IRH and partners designed additional demand creation messages to appeal to audience sub-segments, such as men; those seeking FP services from public, private or FBO providers; and groups with specific practices and attitudes towards FP. In Mali, Rwanda, and Guatemala, messages encouraged men to become involved in SDM use. DRC broadcast SDM promotion messages in the languages of the country's main ethnic groups. In Rwanda and Mali, demand creation materials were adapted for use with several FBO partners to ensure that messages were compatible with religious doctrines.

Some countries were challenged by the imperative of promoting SDM equally alongside other methods, while trying to raise very low levels of awareness of SDM. Because the method was relatively new in scale-up countries, and entirely new in many areas within those countries, it could have benefitted from a stronger focus, while still being situated as one of a range of methods. One solution that IRH tried was to feature SDM boldly in its print media while representing all other methods in smaller images (in contrast to other campaigns, which often focused on single methods, and/or omitted SDM).

IEC channels were diversified and expanded to create a social reputation for SDM.
Table 19 provides a list of approaches by country. IRH supported virtually all demand creation materials and activities during the early years of scale-up, but as other organizations integrated SDM into their programs, they also began to produce their own promotional materials. IRH collaborated with

organizations that specialized in demand creation and had a large reach, such as Population Services International (PSI) and local production companies, to produce and air radio and television spots. Multi-media campaigns were often reinforced by community-level activities such as street theatre and health talks. In Mali, Guatemala, and Rwanda, IRH used edu-tainment and social diffusion to provoke private and public discussions by women and men on SDM and its merits, with the aim of moving from talk (discussion with trusted peers) to action (service-seeking).

Table 19: Demand Creation Approaches by Country

	DRC	Guatemala	India	Mali	Rwanda
Print / Visual					
Murals			X		
Billboards			X		
Posters	X		X	X	
Flyers/Brochures/ Pamphlets		X	X	X	X
Calendars		X			
Mass media					
Television (Spots)	X			X	X
Radio (Spots)	X	X	X	X	
Radio (Drama)		X			X
Radio (Panel)					X
Newspaper (Interviews)	X				X
Magazines (Tear outs)			X		
Community engagement					
Public taxi talks, flyer distribution		X			
Interpersonal Communication			X	X	X
Community Education (Group)		X	X	X	
Social diffusion - mobilization	X			X	X

The results of endline household surveys showed that efforts to encourage diffusion of SDM through interpersonal channels were successful: nearly half (47.2%) of women who had heard of SDM had spoken about the method with someone else, most frequently with a friend or neighbor (43% to 71%) or with their partner (30% to 99 %). Women in Rwanda were far more likely to have discussed SDM with their partner (99%) or a friend/neighbor (71%) than women in other countries, although 65% of Malian women had also spoken with friends. This may be due to the greater exposure to television and radio messages, or to the social diffusion activities implemented in those countries.

Table 20 highlights three approaches for SDM promotion that aimed not only to inform but to foster community discussions about FP and SDM, and ultimately lead to SDM (and other method) uptake. None of these innovations was taken to scale due to funding constraints, although evaluations showed that all resulted in important increases in FP uptake.

Table 20: Three Effective Ways to Promote SDM

Each One Invites 3 Campaign in Rwanda

What: Each One Invites 3 (EOI3), based on the concept of social diffusion, was adapted from the SantéNet Project's successful campaign in Madagascar. Satisfied FP users--women and men--reached out to non-user friends, giving them an 'invitation card' to visit a health center. The act of giving the card allowed a dialogue between the non-user and the user about FP, and invited the non-user to seek services.

How: EOI3 was implemented through community health workers, and through existing men's, women's and couples' associations in four districts that had recently integrated SDM into FP services. Community mobilizers reached out to satisfied FP users to invite potential users to visit FP providers. About 2,000 mobilizers distributed 11,000 cards to friends and peers not using FP methods over six months in 2012.

Results: A 39% increase in new FP users compared to the six months prior to EOI3 campaign; the control area registered a slight decrease in new users. About 4.5% of new users chose SDM, a rate typical for the method. Community perceptions of roles that men play in FP changed, and providers remarked that people seeking services were more articulate in expressing their FP desires.

Radio *Microprogramas* in Guatemala

What: A radio series of short *microprogramas* targeting men and women of reproductive age focused on a variety of sexual and reproductive health issues, including reproductive rights, male participation, FP methods, SDM and CycleBeads

How: IRH collaborated with the Guatemala Federation of Schools of Radio Communication to develop and implement the campaign. The first phase aired on six community radio stations in Spanish, Kaqchikel, Kiche and Mam, with a potential reach of 3,000,000 listeners.

Results: The 2010 evaluation of radio campaign's first phase in Quetzaltenango and Sololá Departments indicated widespread recollection of broadcast messages (of 27 men and 73 women interviewed, 94% spontaneously remembered hearing FP messages). More than 38% of interviewed listeners sought more information about FP after hearing the *microprogramas*; over half visited health centers, as encouraged by the campaign. 71% of listeners also said they spoke to their spouse, family, and/or friends about the messages.

Community Radio in India

What: IRH in India worked with a production company and community radio jockeys in Gumla district to produce 10 radio episodes, replete with songs and dialogue, about issues surrounding FP (including SDM) such as the importance of birth spacing, post-partum FP, and male involvement in FP decision making.

How: The songs and dialogue were then performed by local citizens, and episodes were broadcast in the district, and narrowcast in additional district locations. One episode was male-focused and both male and female community radio jockeys participated.

Results: No formal evaluation was possible at the time, however recommendations for garnering feedback from the community included using post-cards and dial in numbers. Community youth volunteers' enthusiasm helped tackle the sensitive nature of the topic and eagerness to show case their skills was evident.

Limited funds resulted in fewer IEC activities than desired and uneven coverage of awareness raising and demand creation.

IRH's IEC choices were driven in part by available resources: field support funds were limited and core funds were primarily earmarked for research and technical assistance. Consequently, efforts to raise awareness of SDM were often insufficient to reach the goal of knowledge parity with other methods by the end of the scale-up phase in several countries. In all countries, additional resources could have bolstered efforts to level the playing field with other method promotion (particularly LAPM). An independent study conducted by the Futures Institute on the total cost of SDM scale-up in three countries found that communications expenditures totaled $230,150 in Guatemala, $97,438 in India, and $172,056 in Rwanda. Annual expenditures, which ranged from less than $20,000 to about $40,000, were insignificant compared to what most service delivery initiatives spend on IEC. The impact of scarce resources in an environment in which significant resources were being spent on other resources severely impeded SDM scale-up.

While a number of innovative and successful demand creation strategies were piloted, few were implemented at scale. PSI did conduct national-level radio and television campaigns focused on SDM as a new method option in Rwanda and Mali.

Effectiveness of awareness-raising and demand creation

At endline, awareness of SDM compared to other methods varied by country, with some showing knowledge parity (Rwanda and India) and others showing SDM was much less known than other methods (Guatemala and DRC).

In endline surveys, women reported hearing about SDM from community and/or clinic health talks in all countries except for Mali. In DRC and Guatemala, just over half of all women interviewed mentioned hearing about SDM in health talks, as did 43% and 31% of women in Rwanda and India. Health talks were an important source of SDM information for men, mentioned by almost a third of male respondents in India, about 40% of men in Rwanda and DRC, and over half of men in Guatemala. Providers were also frequently cited as a source of SDM information by women in Guatemala (30%), India (54%) and Rwanda (59%). CHWs were mentioned as a source of SDM information only in India (by about half of the women and one-third of the men interviewed).

In countries where PSI conducted media campaigns to promote their contraceptive product line, including SDM, television and radio were frequently cited as a source of SDM information. In Mali, for example, 91% of women and 79% of men reported that they heard about SDM on the television. In DRC, more than one third of women (36.5%) heard about SDM on the television and 44% of men heard about it on the radio. In Rwanda, where there was also a robust social marketing program, 42% of women and 55% of men reported hearing about SDM on the radio. In countries without social marketing programs, media was mentioned infrequently.

In sum, an awareness-raising and demand creation process, and the materials and approaches to support it, are essential for the success of scale-up of an innovation. For SDM scale-up, the level of a population's knowledge of the method, and knowledge of attributes that distinguished it from other methods, were crucial. Equally important were SDM's social reputation within communities, perceptions of SDM's

advantages, and user satisfaction. Shifts in IEC objectives required a diversity of IEC channels, market segmentation, and resources to achieve even exposure to messages.

Figure 13: Sampling of Demand Creation Materials

3.4.6 Cost/Resource Mobilization

Scale-up is a resource intensive process for which significant financial investments are required. IRH began SDM scale-up in 2007 with approximately $30,000,000 in core funding from USAID. Over the next five years, an additional $8,525,602 was leveraged, in cash and in kind, from other sources. This leveraging was important, not only because it provided resources for scale-up, but because it reflected a commitment on the part of contributors to the success and sustainability of the process. Missed opportunities for funding or resources, meanwhile, were often due to a lack of political will or bureaucratic delays.

Contributions from national governments were vital for building their commitment to successful and sustainable scale-up

National government bodies, notably MOHs, were perhaps the most important providers of additional resources, typically in contributions of staff time and expertise in the scale-up-process. Across all five countries, the MOH was a core member of the resource team, and its personnel dedicated countless hours to planning meetings, materials development, trainings, and advocacy for integration of SDM into normative documents. In Guatemala, Mali and Rwanda, MOH officials accompanied IRH staff on M&E trips to witness service delivery, with a focus on training and availability of contraceptive commodities. In Guatemala, the department organized an online self-study course on SDM (originally developed and tested by IRH) that certified over 200 health workers to offer the method. In DRC, the MOH's National Program for

Reproductive Health made a special effort to extend SDM technical assistance to NGOs such as CARE and Jane Goodall Institute that were already working to reinforce MOH capacity. In Rwanda, the Family Planning Technical Working Group, a MOH-hosted task force, ensured integration of SDM not only into facility services but also into its new outreach component of community-based provision of FP. In Mali, the MOH's reproductive health division hosted workshops on scale-up, including the initial strategic planning meeting and the simplification of the SDM training module; the latter led to revised national FP training modules that included SDM. In all countries, MOHs also provided printing resources and substantial personnel time to gauge the quality of SDM provision and method uptake through periodic completion of IRH's KIT and site supervision.

In India, government support was strong, but was expressed at the state rather than national level. The central government prioritized permanent methods and LARC, which meant that SDM was not integrated into national FP norms and could not be supported with central funds. Fortunately, India's decentralized health system meant that Jharkhand could successfully integrate SDM into its FP program. In fact, the Jharkhand MOHFW was the only government entity in any of the five countries that supported SDM scale-up with direct monetary contributions. It provided more than $200,000 over five years, for SDM trainings, printing, and rent for IRH's office. Making its own investments in SDM scale-up gave MOHFW leaders a stake in its success and helped motivate them to ensure that scale-up flourished.

Partnerships with donor-funded projects allowed significant resource leveraging: bilateral projects brought important resources to the scale-up process.

This was evident in IRH's collaboration in Mali (with the bilateral PKC, led by CARE, and with *Assistance Technique National* [ATN+], led by Abt Associates), and in Rwanda (with the Capacity and Twubakane Projects, both led by Intrahealth). PKC provided significant support to horizontal scale-up by using its own resources to integrate SDM into service provider and community health worker training, FP service provision protocol, and IEC materials in its large intervention area. ATN+ personnel devoted time to advocacy and materials development to support SDM's integration into normative documents, extension of health provider trainings in SDM throughout the country, and development of pre-service curriculum for medical/nursing schools. These contributions were largely mirrored in Capacity and Twubakane Projects in Rwanda. IRH also collaborated with the Nutrisalud Project (led by URC) and the PlanFam Project (led by PSI) in Guatemala. After some initial hesitancy, both organizations became members of the resource team in that country.

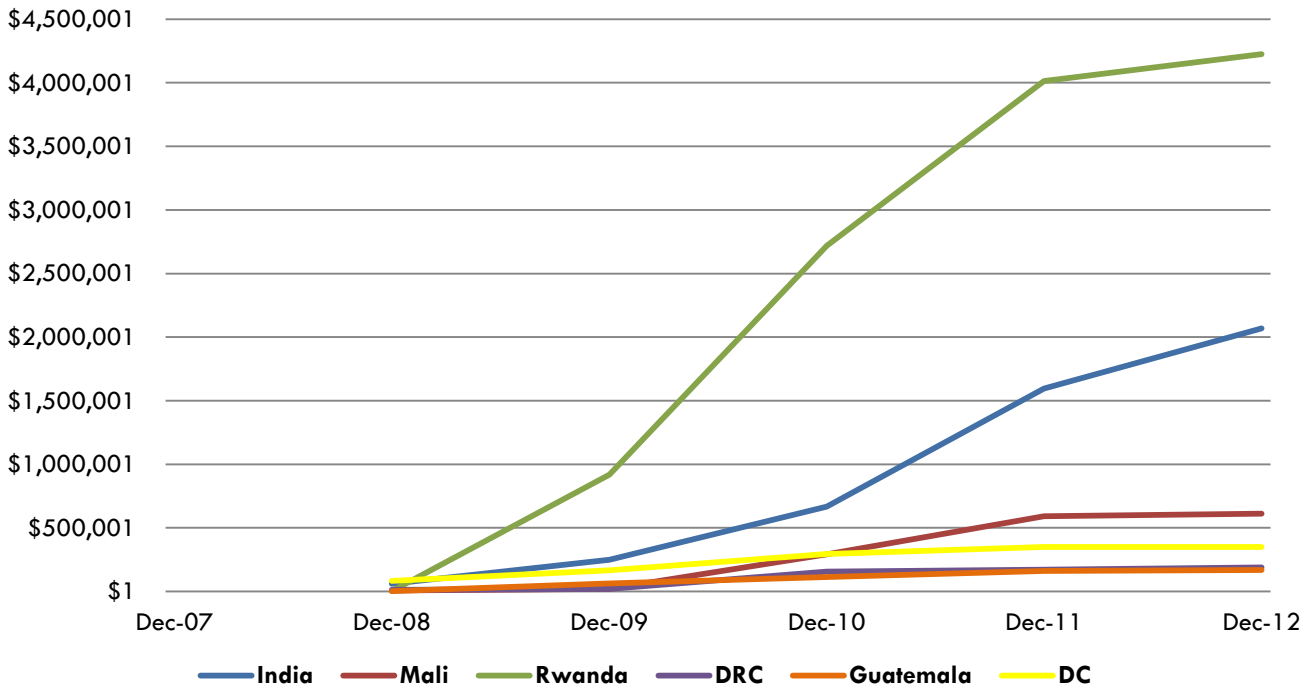


Figure 14: Total Estimated Cost Leveraging By Country During Scale-Up

IRH's work to build organizational capacity often resulted in increased cost leveraging.
IRH provided technical assistance to a number of NGOs, many of which subsequently used their own funds to integrate SDM into FP trainings, service provision and advocacy work in their intervention zones. DRC was particularly successful in this regard: IRH provided funding support and technical assistance to ten organizations to train their providers to offer SDM. One of the ten, the FBO *Conduite de la Fécondité*, in turn used its considerable influence in the African Federation for Family Action to integrate SDM into the natural FP method mix in other member countries, conduct training of trainers, and secured additional funds from the FBO *Eglise en Détresse*. In Guatemala, partner APROFAM trained FP service providers and integrated SDM into service provision. In the same country, well-known women's rights organizations such as REDOMISAR, *Tierra Viva* and the Guatemalan Association of Female Doctors proactively included SDM in their advocacy and training to overcome bias against user-directed methods. In India, NGOs played a slightly different role in resource mobilization because the MOHFW was so involved in SDM trainings: the Futures Group in Uttar Pradesh included SDM in its training and communications materials while Population Council supported monitoring and evaluation during the first few years of scale-up. In Mali, community-based organizations such as women's savings associations and youth groups created awareness of SDM within their social networks after learning about the method during IRH-sponsored training. Local NGO partners in Rwanda were directly funded by IRH, so cost leveraging by these groups was minimal during the scale-up phase; some partners planned to continue SDM services with other funding.

USAID Missions and CAs sought IRH's technical assistance for SDM provision in countries other than the five discussed here. This was an important source of supplementary funding that extended the reach of horizontal scale-up. The USAID Mission in Ghana provided a grant to IRH for technical assistance, an initial

stock of CycleBeads, and evaluation of the effect of adding a new FP method in selected health districts, with the eventual objective of scaling up SDM. Funds from FHI360 allowed IRH to conduct trainings of trainers and pilot introductions of SDM in Kenya and Burundi. Likewise, funds from the ESD Project allowed IRH to conduct trainings of trainers and pilot introductions of SDM in Guinea and Angola. Funds from the C-Change Project allowed IRH to develop and test a paper image of CycleBeads in Benin.

Bureaucracy and a lack of political will constrained what could have been vital sources of support for SDM scale-up.

When scale-up began in 2007, IRH understood that substantial field support funds from USAID Missions in the five countries would be made available to complement USAID core funds. In fact, the donor issued regulations outlining the appropriate use of core and field support funds in scale-up activities: field support was meant to cover the majority of training costs, among other essential scale-up activities, and core funds were earmarked for M&E and research. In practice, USAID Missions provided only modest amounts of field support in most countries. These contributions were inconsistent in Mali and stopped altogether in DRC, Guatemala, and Rwanda. However, Missions expressed support for scale-up by procuring CycleBeads in DRC, Mali, and Rwanda. Initial large purchases of CycleBeads allowed for rapid availability of the product at the start of scale-up in DRC and Rwanda (see also Chapter 3.4.7).

Table 21: Field Support Funding from USAID Missions

	2008	2009	2010	2011	2012
DRC	$312,794	0	0	0	0
Guatemala	0	0	$100,000	$100,000	0
India	$300,000	$300,000	$900,000	$600,000	$900,000
Mali	$150,000	$150,000	0	$250,000	$150,000
Rwanda	$50,000	$50,000	0	0	0

Securing funds and resources from other international donors was hampered by politics and bureaucratic delays. In DRC, the Health Sector Reform Program's efforts to donate CycleBeads proved fruitless because WHO and UNFPA had not integrated the product into their procurement system in that country. An initiative to expand SDM to six additional health zones in DRC via a partnership with GTZ was halted after a political dispute caused that agency to abruptly withdraw from the country. In Guatemala, both the Pan-American Health Organization and UNFPA (at the country level) hoped to fund an expansion of the successful pilot that trained traditional birth attendants to provide SDM. Despite evidence of success and sustained advocacy efforts, they were not able to secure additional funding from their headquarters.

Individual champions of SDM were valuable to resource mobilization.

Individual champions (Chapter 3.4.4) used their own time and resources, and their professional connections, to advocate for greater access to and sustainability of SDM. Faculty at public and private universities in DRC, Guatemala, Mali, and Rwanda provided crucial assistance to update FP (including SDM) curricula for nursing and medical students. In DRC, a professor from the state medical faculty brought the SDM curricula into private institutions where he also taught. A Guatemalan government worker promoted greater awareness of SDM in her free time even when the demands of her job with the MOH restricted her attendance at SDM trainings. The media were also a source of low-cost, high impact resource mobilization

to create awareness of SDM. Key allies in various media outlets in DRC, Guatemala, and Rwanda helped capture the attention of the health community and provided free additional broadcasts of radio programs that included public service messages. A group of mayors in Mali, in a show of solidarity, pledged their personal time to serve as 'mentors' for SDM trainings held by nearby women's associations. Each of these contributions, though small, helped achieve scale-up.

In sum, the value of cost leveraging and resource mobilization was more than monetary. They were also factors in engaging national governments and ensuring their commitment to successful and sustainable scale-up. Cost leveraging from NGOs and other donor-funded projects often developed naturally as a result of IRH technical assistance, and led to SDM trainings and provision in new health districts. Among large international donors, a lack of political will and bureaucratic challenges contributed to missed opportunities for additional funds. Still, even modest contributions had a large impact on the success of scale-up, and modest resource mobilization supported a more robust level of SDM scale-up than would otherwise have been possible.

3.4.7 Procurement

Successful scale-up of a health innovation must encompass access to essential commodities. For SDM, this commodity is CycleBeads which also include user instructions and a calendar. CycleBeads are readily available through Cycle Technologies, the licensed manufacturer/distributor, that has ensured a consistent, low-cost supply of a high-quality product to programs worldwide for more than a decade. However, at the onset of scale-up, CycleBeads was not included in any of the five countries' procurement systems. This posed serious challenges in DRC, Guatemala, Mali and Rwanda, which obtained their FP commodities with donor funds and via donor-managed (especially USAID and UNFPA) procurement mechanisms. This section discusses procurement challenges, and how IRH addressed them. As noted earlier, the fact that we have a manufacturing/distributing partner that is willing and able to help us meet these challenges has proven critical to success.

Including CycleBeads in the USAID|DELIVER PROJECT was a crucial turning point in scale-up and important for sustainability.

CycleBeads procured via USAID | DELIVER PROJECT:

DRC:	550,000
Mali:	3,500
Rwanda:	32,000
Total:	585,500

For SDM scale-up to succeed and be sustained, it was necessary to include CycleBeads in donor procurement mechanisms so they could be ordered like any other FP commodity. In 2009, USAID announced that it would add CycleBeads to the list of FP commodities available through its global procurement mechanism—the USAID | DELIVER PROJECT, managed by John Snow International. This was a pivotal moment in SDM scale-up in Rwanda, DRC, and Mali where IRH had been the sole purchaser and distributer of CycleBeads. The USAID | DELIVER PROJECT went on to procure more than half a million CycleBeads (text box) for these three countries. Allowing MOHs and NGOs to procure CycleBeads through the USAID | DELIVER PROJECT ensured sustainable access to the commodity after IRH's role ended. The USAID | DELIVER PROJECT also supplied valuable political and technical support to scale-up by resolving distribution issues at the health facility level in DRC and Rwanda.

A prerequisite to including an innovation in commodity forecasts is integrating it into national normative documents.

The USAID | DELIVER PROJECT decision to procure CycleBeads was important, yet USAID remained the sole international donor to regularly purchase and distribute the commodity for FP programs. To overcome this barrier, IRH learned that it was necessary to advocate with MOHs to include SDM in their national FP norms. Over the course of SDM introduction and scale-up, the MOHs in Rwanda, Mali, DRC, and Guatemala did so, and this made it possible for them to request that international donors procure CycleBeads for their FP programs. USAID met the requests made by DRC, Mali, and Rwanda. In Guatemala, where UNFPA procures FP commodities, the request was not met, even though the MOH was willing to use its own funds for this purpose.

India was the only scale-up country in which SDM was not included in national norms. SDM was approved at the state level, but IRH's advocacy efforts did not have a similar reception at the national level due to government and donor emphasis on LAPM. SDM's absence from national FP norms in India kept CycleBeads from being procured by the Indian government or by any international donor. IRH was the primary source of the commodity until 2011, when local manufacturing was established through a sublicense from the global manufacturer. Even then, after Cycle Technologies and IRH expended significant resources in establishing local manufacturing and distribution capacity, local procurement is minimal.

Stakeholder preference for LAPM and the lack of international donors, except USAID, willing to purchase CycleBeads, challenged procurement and sustainability.

With SDM successfully integrated in the national FP norms of four of the five countries, IRH continued to advocate with other international donors to procure CycleBeads. However, no major donor responded. UNFPA's stance evolved but did not resolve in favor of CycleBeads before the scale-up phase ended. Guatemala's National Commission on Contraceptive Security requested that UNFPA (which is responsible for contraceptive purchasing in that country) procure CycleBeads, but it refused on the grounds that CycleBeads were not included in WHO's essential medicines list. In DRC, USAID and UNFPA shared responsibility for funding reproductive health programs, and each provided technical support and contraceptive supplies to agreed regions of the country. Although CycleBeads were included in DRC's national FP norms and were present in USAID-supported regions, they were not available in UNFPA-supported regions. CycleBeads gradually became available nationwide in Rwanda as the MOH used USAID-purchased CycleBeads to cover all zones, regardless of which donor supported which zones.

In 2012, after advocacy by champions within WHO and IRH, WHO issued an advisory note on CycleBeads that reinforced the commodity's quality standards and effectiveness as a tool for use with SDM. This advisory was an important advocacy tool to influence UNFPA. In 2013, after the scale-up phase closed, UNFPA established an agreement with the manufacturer and distributer of CycleBeads to procure the commodity for countries that earmarked their own funds for it. However, UNFPA still does not procure CycleBeads directly.

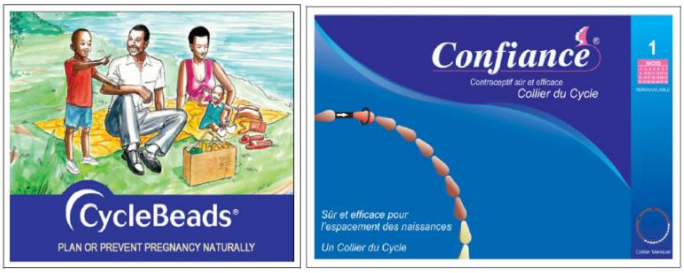
In Mali, Rwanda and India, political and donor preference for LAPM reduced support for CycleBeads procurement. In Mali, for example, PSI and Marie Stopes International initially promoted and distributed CycleBeads via donor-supported projects. Upon receiving follow-on funding to support LAPM, these NGOs

de-emphasized SDM in their work with communities and public/private facilities. In Rwanda, IRH successfully advocated that SDM be included in the performance-based financing system (World Bank) in 2009, thus giving providers the same incentive to offer SDM as any other FP method. However, by 2011, SDM was removed from the system when new MOH did not recognize its importance.

Accurate service reporting is essential if commodity forecasting is to meet true demand.
IRH worked with MOHs at the policy level but also addressed important integration issues at the program level: inclusion of SDM in HMIS and service reporting forms. Accurate contraceptive forecasting relied on accurate user data from facilities, but none of the five countries' HMIS forms accounted for SDM at the onset of scale-up. Rather, providers had to record SDM users in columns labeled 'other' or even in the margins of their forms. Collecting and aggregating these data accurately and efficiently proved difficult for providers and data managers. Ultimately, IRH addressed the barrier of SDM data collection by advocating with governments to include SDM in their HMIS. By the end of the scale-up phase, HMIS included SDM reporting lines in DRC, Mali, and Rwanda, was in process in Guatemala, and was not possible in India, since the central MOH had not yet included SDM in it norms. (User data also represented demand for SDM and were important for advocacy to include CycleBeads in national procurement tables.)

IRH's strong coordinating role in logistics and procurement was not sustainable post-scale-up.
Even as IRH and partners continuously advocated with international donors to procure CycleBeads like all other FP commodities, IRH had to maintain a significant role in CycleBeads logistics and procurement in each of the five countries. Several factors dictated this. Until SDM was included in the HMIS and service reporting forms, decision-makers did not have correct data about method use, and were thus unable to accurately forecast for CycleBeads needs. Combined with weak logistics systems, this resulted in several instances of IRH providing supplies of CycleBeads directly to facilities to fill gaps. In DRC, for example, the government's capacity to manage the logistics of FP commodities was weak, so USAID and UNFPA played this role. IRH had to supply CycleBeads to (a) facilities that received international support from donors other than USAID, and (b) facilities that had no international support for FP.

In other countries, NGOs that did not have USAID support also found it difficult to access CycleBeads without IRH's help. In Guatemala, where UNFPA procured FP commodities on behalf of the MOH, IRH was the primary purchaser and distributor of CycleBeads for the entire public and private sectors. The primary supply of CycleBeads in India was an IRH donation until local manufacturing was established in 2011. While local manufacture increased the likelihood of a sustainable CycleBeads supply, most funds for purchasing CycleBeads continued to come from IRH with USAID support, and not from India's government or other international donors.



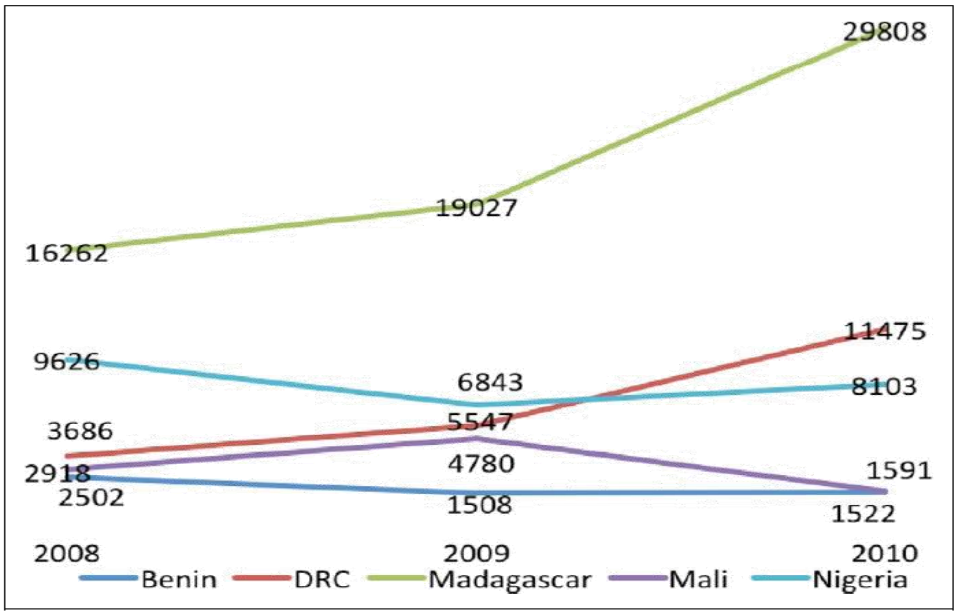
CycleBeads have been socially marketed by PSI and others in a variety of countries worldwide. The branding for CycleBeads is tailored to each local context.

Private sector distribution of CycleBeads was successful, but donors subsidized procurement.
Throughout scale-up, IRH and partners also paid attention to private-sector commodity distribution channels. In DRC, Rwanda and Mali, PSI purchased and distributed CycleBeads through its social marketing programs with funding from IRH grants, starting at the same time as, or even before, the scale-up phase began (Figure 15). PSI found that SDM users were willing to pay for CycleBeads at outlets such as pharmacies and boutiques.

The primary challenge to scale-up of sustainable SDM services through social marketing programs was the funding to purchase and promote CycleBeads. In most cases, IRH provided grants to PSI to buy the commodity and/or donated CycleBeads to PSI. In some cases, PSI purchased CycleBeads through its own projects, but only if the projects were USAID-funded. (Other donors of social marketing programs, such as KFW, have not yet purchased CycleBeads, and CycleBeads are not yet in these donor procurement mechanisms.)

In Guatemala, after years of negotiation, IRH secured local distribution of CycleBeads through APROFAM, an IPPF affiliate and the country's largest private-sector FP provider. APROFAM began social marketing, promotion, and distribution of CycleBeads in 2013 through its own networks and local NGOs. An initial donation of CycleBeads from IRH allowed APROFAM to create a revolving fund to purchase and import the commodity in the future. APROFAM segmented the market to establish price differentiation for public and private sector buyers, a strategy that will allow a return on investment through commercial sales while still subsidizing prices for the public and non-profit sectors.

Figure 15: Sales of CycleBeads in Sub-Saharan Africa, by Population Services International (PSI) 2008–2010



In sum, IRH facilitated most of the initial CycleBeads supply in each of the five countries because the commodity was not yet integrated into global or national procurement mechanisms. After five years of

scale-up, partners in Rwanda, DRC and Guatemala demonstrated the ability to procure CycleBeads through non-IRH channels (including USAID | DELIVER, PSI or other NGOs as local distributors) and India began local manufacture of CycleBeads. In Mali, CycleBeads were on the contraceptive procurement table and will likely be included in future MOH procurement. While barriers still remained (notably, funding for CycleBeads, access to CycleBeads for non-USAID-funded organizations, and in-country logistics of getting CycleBeads to the facility level), great advances were made in logistics, procurement and supply chain management during the SDM scale-up phase. Findings indicated that sustainability of CycleBeads procurement and logistics improved, but further efforts were needed to ensure SDM's full integration into the national FP program in all five countries.

3.5 How Was Scale-up Achieved? Usefulness of ExpandNet Framework and Principles of Systems Thinking, Sustainability, and Scalability

3.5.1 Overview

ExpandNet Guiding Principles

1. Systems Thinking
2. Sustainability
3. Scalability
4. Respect for rights, equity, and gender perspective

Scale-up is a complex, non-linear process; it involves many interrelated factors that are subject to near-constant change. IRH chose the ExpandNet framework (see Figure 2, page 6) as a systems-focused tool for breaking this process into components that could be more easily understood and acted upon. The framework lays out four principles to guide the work of scale-up. IRH's experience of the utility of the framework and its four guiding principles are the topic of this section. It begins with brief definitions of the first three guiding principles (systems thinking, sustainability, and scalability), then discusses how these supported the framework's value as a planning, monitoring and staff development tool. The section concludes with reflections on how the framework helped shape IRH's application of the fourth principle: respect for rights, equity and gender perspectives in each of the five scale-up countries.

3.5.2 Usefulness of ExpandNet Framework and Principles of Systems Thinking, Sustainability, and Scalability

Systems thinking. The framework helped resource teams view scale-up as taking place within complex systems and understand how the systems' components worked together and affected one another. Regular review of the scale-up process through the framework's lens helped staff and stakeholders better understand that systems constantly change and analyze how a change in one or more components could affect the success or failure of the whole. Systems thinking went beyond SDM scale-up alone because resource teams used scale-up as an opportunity to strengthen the larger health system in each country

"The notion of sustainability and capacity building has to be implied [in the definition of scale-up]. All of our programs have from the start focused on institutional capacity building, and they continue to do so. All this has given the results we see today."

– IRH Country Representative, Mali

"If it were just a question of growing and service provision during scale-up, then when it stopped everyone would just forget about it. And that's what happens with many programs."

– IRH Country Representative, DRC

while facilitating SDM integration, including policy environment, workforce development, and HMIS improvements. Health systems strengthening was a natural extension of the systems thinking required to use the ExpandNet framework.

> "We need to be able to map out the steps. The ExpandNet framework helps us do that."
>
> - IRH Staff, India

Sustainability. The notion of sustainability was embedded in the ExpandNet definition of scale-up used by IRH and partners: *deliberate efforts to increase the impact of health service innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and programme development on a lasting basis*. IRH's goal was to mainstream SDM within each country so that high quality SDM services would remain available indefinitely after the scale-up phase was over. This led to IRH's strategic choices, such as integrating the method into public and/or private sector health systems and transferring capacity to user and resource organizations so they could 'graduate' from needing IRH's technical assistance. Resource teams also worked to ensure that the policy gains for which they advocated were not reversed.

Scalability. IRH took the principle of scalability into account when defining the revised SDM innovation package for expansion in each country (Chapter 3.3.5). SDM was designed from inception to be scalable: research showed it to be an easy-to-use, easy-to-teach FP method. Still, streamlining and simplifying the innovation package was necessary to make it suitable for large scale expansion in each specific country context.

A tool for planning scale-up. At the outset of the scale-up phase, IRH and partners in each country used the ExpandNet framework to plan a multi-year scale-up strategy. Launch meetings and strategic planning workshops held in Washington, DC and in the five scale-up countries were opportunities to formally present scale-up, emphasizing its systems focus and positioning the MOH and IRH as leaders in the process. At most of these meetings, the ExpandNet framework was used as an important orientation and planning tool. Reviewing all the components of the framework in light of their countries' situations gave planning teams a more complete understanding of what scale-up would require and the barriers and opportunities they might encounter. It was a way to structure and systematize discussions around scale-up planning. Many staff referred to the ExpandNet framework as a 'road map.'

> "[At first] it was confusing to me, it seemed complicated… It's hard to understand when you look at [the ExpandNet framework graphic], but the more you get involved in it the more you begin to understand it, because the environment, a team, advocacy, logistics, the whole implementation of the process are important. You have to get involved to understand how it works."
>
> - Guatemala MOH/PNSR Member

> "At first we were wondering whether it has a positive purpose or what its scope would be, but as we got further, I was won over by the framework. I believe it is the best way to work with the population."
>
> - Guatemala MOH/ Area of Health Member

Following these initial meetings, IRH in India, Rwanda, and DRC used the ExpandNet framework primarily as an internal planning tool: staff felt that it would distract from, rather than add value to, interactions with partner organizations, whether resource or user

organizations. They opted to explain and discuss the systematic nature of scale-up to partners without explicit use of the ExpandNet framework.

In Guatemala and Mali, however, the framework was used to engage and involve resource and user organizations. The ExpandNet framework's status as a global tool, endorsed by WHO, attracted high-level MOH staff and scale-up partners in these countries. Using a systematic plan for scale-up activities helped organizations see how their participation was important, especially smaller NGOs that felt they lacked influence. In Guatemala, working through the framework was a formative activity for the resource team, which chose to go a step further and organize sub-teams around components of the framework, such as political environment, M&E, training, and awareness-raising.

A tool for monitoring throughout the scale-up phase. The ExpandNet framework encourages 'beginning with the end in mind.' This led to the creation of benchmark targets that numerically described each country's intended achievements, annually and by the end of the scale-up phase. IRH developed monitoring tools based on the framework components. Progress toward benchmarks, as captured by these tools, was reviewed semi-annually in each country to track the overall status of scale-up with respect to the ExpandNet framework. In Mali, for example, the initial planning workshop and field visits resulted in a multi-organizational strategic plan and recommendations for scale-up. This strategic plan and the ExpandNet framework's various components then served as the basis for annual review meetings. Analysis of the framework's elements, reinforced by the results of research and M&E, guided the creation of yearly activity plans. This process allowed IRH and partners to make the best strategic choices in light of available resources.

> "I remember in Rwanda at the beginning, we talked a lot about 'extension'. Extension in 13 sites, and extension in 15 new sites, and in 39 sites, and at that time, I never thought of institutionalization. I thought more about the geographic coverage and horizontal integration than I did about vertical integration. But [with] the Expand-Net framework, I realized that what we were doing was not enough, and in fact it was only one aspect."
>
> - IRH Country Representative, Rwanda

> "[A]t the beginning…we are in one village, then we go to another one, and another…and that's how we understood scaling-up. But with the ExpandNet framework, now we understand that it is a question of growing up, but growing with roots."
>
> - IRH Country Representative, DRC

Impact on staff thinking and roles. The ExpandNet framework helped IRH staff make the mental shift required for moving from the SDM introductory phase to SDM scale-up. Prior to adopting the framework, IRH staff sought opportunities to spread SDM availability in all five countries but did not necessarily focus on actions needed for sustainability. ExpandNet provided a comprehensive picture of the work required to achieve both. It sharpened the focus on the need for and elements of institutionalization of the innovation, alongside the more evident need for geographical expansion.

This mental shift led to evolving roles and development of new skill sets for IRH staff. Before scale-up, staff in most countries devoted resources to conducting trainings in new locations and for new organizations. With the onset of scale-up, IRH became a provider of technical assistance to other organizations that

conducted the bulk of the trainings; this gave IRH latitude to tackle broader issues highlighted by the framework, such as integrating SDM into systems and policies, advocacy, and M&E.

Staff benefited in other ways from using the ExpandNet framework. For example, it provided a common vocabulary with which to discuss SDM scale-up activities and strategy and was a valuable tool for orienting new staff to the work of scale-up.

Informative for global planning and technical assistance. The ExpandNet framework was also useful at IRH headquarters in Washington, DC, where it provided a shared language with which to describe the scale-up process and helped elucidate a shared vision of work for all staff. Reviewing country-specific progress through the framework's lens helped IRH's global leaders better understand what was occurring on the ground and make strategic decisions, such as where to invest resources. Similarly, it pointed to areas where global-level intervention could facilitate country-level work, such as advocacy for SDM integration into worldwide procurement systems and essential medicines lists. Finally, the framework provided a structure for reporting scale-up results across countries.

In sum, IRH and its partners in all countries found great utility in the ExpandNet framework for systematically conceptualizing and planning, engaging stakeholders and partners, managing and monitoring, and evaluating SDM scale-up achievements (Table 22).

Table 22: Usefulness of a systems-oriented framework to guide-scale-up

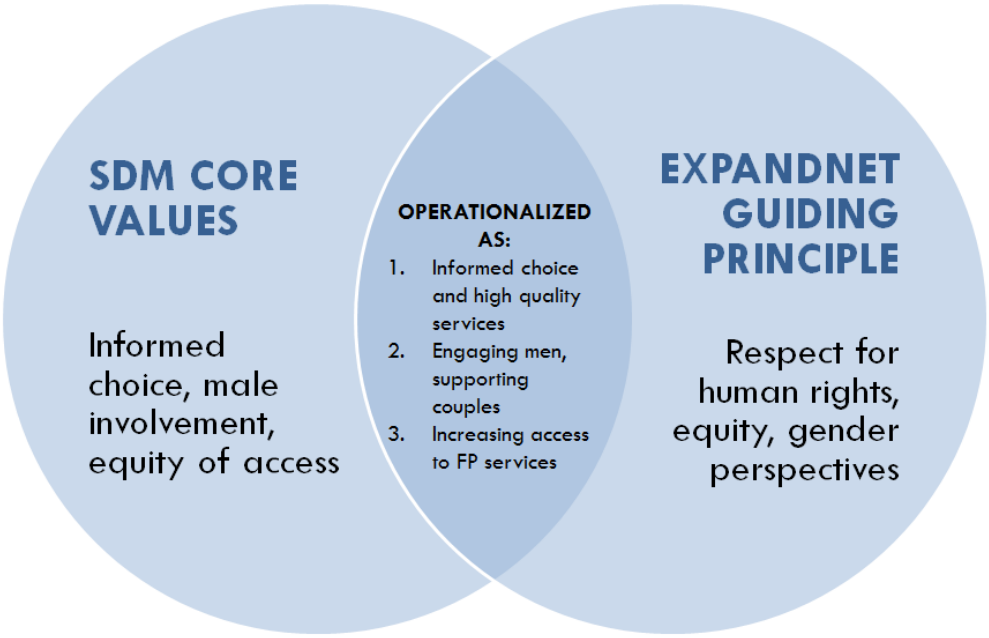
Scale-Up Function	The framework helped to…
Planning	Foster shared vision / serve as road map and planning tool / facilitate understanding of scale-up requirements / identify barriers and opportunities / delineate relations between systems
Advocacy & Stakeholder Engagement	Identify potential partner role / develop work plans involving multiple partners / identify areas for advocacy
Managing The Scale-Up Process	Provide common scale-up language / inform realignment of staff roles for scale-up / highlight areas for staff development / teach systems thinking / maintain focus on activities that promote sustainability / prioritize activities / keep focus on guiding principles
M&E	Develop indicators and benchmarks / guide annual reviews / organize analyses and reports / assess changing environment and systems

3.5.3 Application of the ExpandNet Framework's Fourth Principle: Respect for Human Rights, Equity, Gender Perspective

When defining the SDM package and planning scale-up, IRH held discussions with staff and partners about how the ExpandNet framework's *guiding principles* overlapped with SDM's *core values* and to what extent they should be placed front and center during scale-up. (Recall that IRH assigned the core values of *informed choice, male involvement* and *equity of access* to SDM.) In the end, IRH and partners chose to operationalize the ExpandNet principles in a way that would be practical and relevant to SDM scale-up, choosing to focus on: (1) offering SDM within the framework of informed choice and ensuring high quality services; (2) engaging men and supporting couple communication and shared decision-making; and (3)

increasing access to FP services. Each of these is described below, followed by examples of how they were operationalized during SDM scale-up.

Figure 16: Guiding principles and core values become a relevant, practical focus for scale-up



Informed choice and quality services. Respect for human rights was a centerpiece of SDM scale-up. An essential tenet was that the method be taught within the context of the full range of FP methods. Further, good quality counselling should be available for all methods, allowing women and their partners to be knowledgeable and free to choose the method most suitable for them. In presentations, orientations, advocacy talks, and trainings, SDM was promoted in the context of a client-centered, multi-method FP program. Capacity building was designed such that introducing SDM into an existing mix of FP methods would improve the quality of counselling for *all* methods and allow people to exercise their right to freely choose.

IRH's attention to quality and evidence-based approaches was another way it operationalized respect for human rights and equity. The SDM innovation itself was evidence-based, and a variety of M&E strategies ensured that SDM remained effective and beneficial. These included participatory methods such as MSC to amplify the voice of the consumer. As SDM expanded to new areas, IRH and partners developed and implemented tools to monitor the quality of counselling (KIT) and correct method use (CFU). Data were continually reviewed and shared, and adjustments made as needed. When some strategic areas were seen to fall behind others, staff gave increased attention to the poorer performing areas to troubleshoot and resolve problems.

Engaging men and couples. Many FP programs are geared toward women, but IRH and partners enacted the guiding principle of respect for gender perspectives by emphasizing the importance of male participation. SDM counselling included teaching women how to engage their partners in using the method and discussing reproductive issues more generally. In some cases, both men and women were counselled

in method use, and outreach messages were geared toward couples (and sometimes toward men). Scale-up in Guatemala contained a particularly strong rights and gender component. SDM trainings included sexual and reproductive rights, the responsibilities of both sexes for FP, and women's right to make decisions about their own bodies. Trainings referenced international norms and Guatemalan laws pertaining to universal access to FP, using case studies and interactive sessions to discuss sex, sexuality, gender, and gender roles. Also in Guatemala, IRH worked with national women's organizations on advocacy issues.

Increasing access to services, or equitable access. To promote equity, IRH made a priority of reaching underserved and isolated areas. The scale-up strategy made use of community health workers to bring SDM to those who lacked access to facilities, and staff ensured that educational materials were suitable for low literacy populations. In India, scale-up districts in Jharkhand were selected based on greatest need for FP services, even if it meant working in hard-to-reach areas.

3.5.3.1 Equity: Expanding Access to FP by Engaging FBOs

IRH had significant successes working with FBOs to reach underserved groups, thus reducing barriers to FP use in some settings. Introducing and scaling up a natural FP method such as SDM might appear straightforward within a religious context, yet several barriers had to be overcome.

Obtaining and Maintaining Political Will. In any organization, the political will of leaders is crucial for change. To introduce and scale-up SDM in health services provided by FBOs, it was necessary that FBO leaders champion the effort.

For example, Caritas health services constitute a mixed FBO-MOH network that manages about 30% of health facilities in Rwanda. Caritas was interested in contributing to the national FP program, and SDM—recognized as both a modern and a natural method by the MOH and the Catholic community in Rwanda—offered a prime opportunity. But Caritas needed official approval from Rwanda's Catholic Church to do so. As part of SDM scale-up, IRH and its partners encouraged Church leadership to sanction the method and cleared the way for collaboration with Caritas-managed services.

> "There was a great collaboration with religious leaders. Even those who did not understand, those who objected to any mention of barrier methods during the fertile period rather than abstinence.
>
> Eventually, there was consensus. All agreed and found mutual respect. I know that in certain sites, at certain moments, they said, 'No, we will not offer this method.' But IRH sought and found solutions, pursued collaboration and negotiation until they understood the basis of the method, and the program could continue as planned. [IRH] really knew how to manage the various elements, opportunities, and challenges, to bring the program to scale."
>
> - NGO representative, Rwanda

Leaders of the Catholic Bishops Conference of India favored SDM's integration when the method was first introduced in that country. IRH and the Conference developed a formal memorandum of understanding and an action plan for integrating SDM into demand generation efforts and to build capacity within nursing school programs funded by the Conference. However, just before scale-up was launched, Conference leadership changed and the political will for SDM integration was lost.

Leaders of some Catholic groups were beholden to national and international higher-ups, many of whom

were strong advocates of the Billings Method or other natural methods. In Guatemala, IRH tried to integrate SDM into the faith-based sector through two FBOs, St. Peter's University and Caritas. A third group, the San Pablo Community, a nationwide service arm of the Catholic Church, expressed interest in selling CycleBeads in its bookstores. None of these groups was allowed to proceed without a written endorsement of SDM by the Catholic Church. IRH and partner efforts to secure official approval of the method from the Church were not successful, so these FBOs were not able to offer SDM.

In DRC, IRH worked with the Catholic FBO, *Conduite de la Fécondité*, which had long provided natural FP education. *Conduite*'s commitment remained steadfast despite concerns of some in the organization that SDM was not truly a natural method (because it does not 'require' abstinence on fertile days; using a barrier method is an option). The *Conduite* director and her team worked to dispel myths within the FBO and the community, even approaching Catholic Church leaders to persuade them that because FP was a couple's decision, it should be the choice of each Catholic couple—and not of the Church—to choose SDM or another natural method. Through its partnership with *Conduite de la Fécondité*, IRH learned that the best advocate for SDM integration in FBOs was often FBO members themselves. Therefore, IRH made particular effort to offer training and support to FBO representatives who were interested in SDM and adapted the CycleBeads Instructions and other materials to include language and images appropriate for the Catholic community.

> "This effort to integrate SDM into the logistics system has marked an outstanding point of collaboration between FBOs and the government, and IRH has contributed a lot."
>
> - Caritas provider, Rwanda

Mention of condoms. Catholic leaders' initial reaction to SDM in Rwanda and DRC was not positive. Because SDM is positioned as a method that encourages couples to choose how to handle fertile days (through either abstinence or use of a barrier method such as condoms), some Catholic leaders felt it was not consistent with Church teachings on FP.

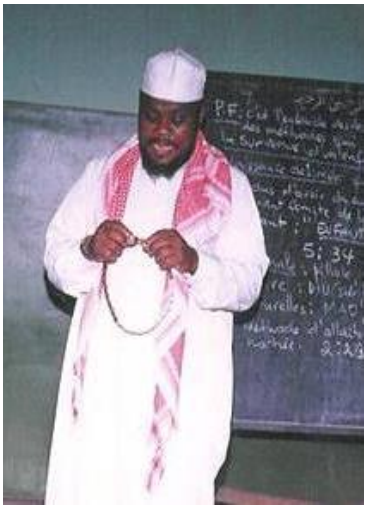
One stakeholder in Rwanda said, 'I recall that at a certain moment the bishop at Butare said that SDM had to be stopped because it was a way of promoting condoms.' IRH staff in Rwanda advocated with FBO leaders, explaining that SDM could be used within the Catholic context because SDM did not dictate how the fertile days should be managed; rather, it was the choice of the user couple to abstain or use a barrier method. Caritas in Rwanda had no problems with mention of condoms in elements of the innovation package, but the FBO *Action Familiale* did so IRH created a sub-set of training materials and user instructions that eliminated all mention of condom use. Even still, *Action Familiale* had challenges when procuring CycleBeads because the standard sets procured in the country include instructions that mention condoms *Action Familiale* has now decided to access CycleBeads from the MOH and to print their own instructions.

> "The method, in effect, jump-started the active participation of church-run facilities in the national family planning program. FBOs, for their part, indicated that the arrival of SDM prompted the Catholic Church in Rwanda to write policy and instructions for Catholic-run health facilities to more actively promote natural family planning methods, including SDM."
>
> - Rwanda FBO stakeholder

> "[SDM promotion] had a positive impact on the state's and other actors' knowledge of the Church's role in FP…Church health centers are no longer considered zeroes by District Health Supervisors, as they were before."
>
> - Rwanda FBO stakeholder

While some barriers related to lack of political will might have been overcome with more vigorous advocacy, IRH had to balance such advocacy against maintaining the brand identity of SDM. IRH was strongly committed to and strove to maintain informed choice when introducing and scaling up SDM. It did not want MOHs and others in the global health community to view SDM as a stand-alone intervention only appropriate for FBO providers and their clientele.

Partnerships with FBOs were mutually beneficial; collaboration with IRH resulted in improved organizational capacity for many FBOs. Because of SDM's core values and unique characteristics, IRH was able to work with many FBOs in ways that other FP organizations could not. SDM resonates with faith communities because it is natural and directly linked to fertility concepts. Moreover, SDM use involves both the woman and the man, a feature that aligns with many religious communities' aims to strengthen the family. As a result of collaboration with IRH, the FP capacity of many FBOs was improved.



An Imam in DRC demonstrates how to use CycleBeads

Many FBOs had no formal relationship with the MOH or national FP program and thus received no government support to carry out their work. Their FP services tended to be weak and under-resourced, often relying on volunteers. *Action Familiale* in Rwanda, for example, is a coalition of volunteer community educators who counsel couples on natural methods. Before partnering with IRH, *Action Familiale* received no monetary support of any kind from the Church or the government and had few training resources and protocols for monitoring and evaluating its work. Partnership with IRH helped the FBO develop its organizational capacity in important ways: it created a set of training materials for awareness-raising activities and began using the KIT to conduct routine monitoring of FP educators to ensure high quality service provision.

> "Muslim women were trained in family planning, but gender barriers still existed because women cannot speak with men about matters of sex. Therefore, Imams were trained…to spread the word about family planning and SDM."
>
> - IRH Country Representative, DRC

Before its partnership with IRH, Caritas-managed health facilities in Rwanda participated unevenly in the national FP program. Some facilities offered natural methods while others had no FP services and referred clients elsewhere. The MOH's HMIS did not explicitly name natural FP methods, and MOH was not consistent in asking for natural FP service statistics from Caritas health facilities. In short, Caritas' contributions to the national FP program were not counted. IRH helped Caritas integrate the revised MOH service reporting forms, which included SDM as a unique category and 'natural methods' as a generic category. The contribution of Caritas facilities to the FP program became more systematic and far more apparent to the MOH.

In DRC, IRH collaborated with *Mamans An'sar,* a Muslim women's network, to promote FP services among Islamic couples in Kinshasa for the first time. Group members embarked on several years of advocacy with

religious leaders that culminated in training, advocacy with and by imams, and awareness-raising and distribution of CycleBeads in communities. In fact, *Mamans An'sar*'s advocacy led DRC's national Islamic council to develop a consensus on FP. It created a formal declaration supported by Koranic citations that endorsed FP for Muslims. *Mamans An'sar* was then able to discuss other modern methods with imams and help them incorporate FP messages into their Friday sermons. Over time, IRH and *Mamans An'sar* added almost the full range of FP services to facilities and community-based distribution serving the Muslim community. Independent of IRH, *Mamans An'sar* began working with its chapter in remote Maniema Province to launch FP activities there.

FBO involvement generated demand, improved attitudes towards FP, and increased access to services among followers. FP perceptions are strongly affected by religion. By working with FBOs and religious leaders to introduce SDM, acceptance rose and significant demand was generated. In Mali, for example, many Muslim leaders were openly opposed to modern forms of FP, claiming them equivalent to abortion. According to community leaders interviewed in 2009[54], Islamic religious leaders were in favor of using natural FP. SDM provided an opportunity to renew the discussion and indeed was a gateway to discussing other methods. IRH leveraged this opportunity by conducting trainings for networks of religious leaders that presented general fertility and FP concepts, addressed myths, and promoted SDM.

IRH's choice to actively involve Congolese FBOs of various denominations, along with other key stakeholders, accelerated the spread of and demand for SDM in DRC. 'Working with religious and community leaders allowed for greater acceptance of SDM because of the great trust people put into them,' observed one stakeholder. *Conduite de la Fécondité* played an invaluable role advocating with other FBOs to integrate SDM as a natural FP option, which led to a rise in the number of FP users. Both *Conduite de la Fécondité* and *Mamans An'sar* convinced religious leaders to advocate for FP and to refer couples and women with unmet need to service providers. In Rwanda, the Catholic Church accepted SDM as a natural method compatible with its beliefs, and church-linked services adopted the method. One stakeholder said, 'With the innovation of SDM, it was like a drop that began to fill a pond that had been empty. And the [pond] filled quickly.'

In sum, FBOs have great potential to expand access to SDM and create a supportive environment for it and other FP methods, but strategies for engaging FBOs must be tailored to the cultural context, the particular faith tradition, and the strength of leadership support within the organization.

3.5.3.2 Equity: Expanding Access to SDM outside of Health Facilities

Another way that IRH pursued equitable access was to prioritize activities that would serve hard-to-reach populations. While integrating SDM into health facility services was a simpler and less costly task, IRH and partners were committed to bringing SDM to those without access to facilities. The intrinsic characteristics of SDM make it feasible to provide through community health worker networks (including trained birth attendants and community-based distributors), community-based organizations, FBOs, and the private sector via social marketing channels.

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[54] Institute for Reproductive Health, Georgetown University for the United States Agency for International Development. June 2010. *Stakeholder Perceptions of Integration of Fertility Awareness-Based Methods (FAM) in Mali: Current Status and Future Directions*. Washington, D.C.

Prior to SDM scale-up, IRH conducted studies in several countries to determine the feasibility of using non-facility SDPs to offer SDM services. Results from where SDM was integrated into community health worker networks (Guatemala, India and Rwanda) and where it was distributed via social marketing channels (India and DRC) indicated that SDM could be offered by community health workers and pharmacy assistants at a similar level of quality as providers in health facilities if provided adequate training and support. Community health worker studies further showed that SDM uptake was higher in community programs than facility programs, in part because community agents were closer to clients, could spend more time on counseling, could involve men in method use, and could raise awareness in home and community settings.

SDM delivery beyond clinic walls.

During the SDM scale-up phase, IRH identified several platforms upon which to expand SDM access, including traditional birth attendant networks, FBO social services, and women's savings and loan associations. IRH and partners were also quick to seize new opportunities to expand SDM services beyond health facilities. In DRC and Mali, for example, PSI began to shift all its FP products from pharmacies to community health vendors, and this led to proportionately greater CycleBeads sales than through pharmacies alone. In Guatemala, offering SDM through trained birth attendants responded to the MOH's task-sharing initiative. In India, IRH and partners made SDM available to more affluent markets via online sales of CycleBeads. By the end of the scale-up phase, SDM was offered via four types of non-clinical service delivery channels, significantly expanding the number of SDPs in each country. Table 23 shows these channels, and the countries that used them to expand access to SDM.

Table 23: SDM Services Outside of Facilities

Service Type	Supported by…	DRC	Guatemala	India	Mali	Rwanda
Community Health Workers, various types	MOH, NGO	■	■	■	■	■
Private pharmacies and retail outlets, community health vendors	NGO social marketing	■		■	■	■
Couples counseling, family life services	FBO	■	■			■
Community based health & non-health organizations	NGO	■	■		■	■

IRH identified several factors that facilitated SDM scale-up outside health facilities. First, working with existing networks and groups, already established and recognized in communities, meant more rapid expansion and economies of scale. There was no need to create structures to expand access to SDM, but only to provide SDM-specific training, supportive supervision, and the like. Second, simplification and adaptations made to the innovation package, described in Chapter 3.3.5, facilitated SDM expansion outside communities. IRH and PSI research in Mali, for example, led to a further simplification of the user insert so that women who were literate at or above the third grade level could learn to use SDM without provider counseling. This allowed CycleBeads to be marketed in small retail outlets. Third, implementing social diffusion campaigns through existing community-based organizations provided quick wins for SDM uptake. Campaigns in Mali, Rwanda, and Guatemala saw rapid success in raising SDM knowledge and acceptance, and this held true whether the community-based organization was health-focused or not.

Likewise, several factors limited SDM scale-up outside health facilities. First, community-based networks needed, but rarely had, long-term access to training and supervision, IEC materials, and SDM commodities. In Mali, to take just one example, community-based FP services (including SDM) were rolled out at a very large scale under the aegis of bilateral health programs, but their post-program sustainability was not assured. Second, community-based distributors and clients in some countries were rewarded for providing some methods, and this discouraged SDM update. Large networks in India and Guatemala used cash and other incentives to motivate community volunteers to refer women for LAPM. In Mali, combined FP/immunization programs reached tremendous numbers of people, but offered only LAPM at the immunization sites. Finally, it became clear that private-sector pharmacies were not suitable SDPs: for pharmacists, CycleBeads were a one-time sale with a low profit margin, took shelf space from more lucrative products, and required time-consuming client counseling that prevented attention to other paying customers.

3.5.3.3 Gender: Engaging Men and Couples

Gender norms—social expectations surrounding the appropriate roles, aspirations and behaviors of men and women in a given society—have a tremendous impact on FP use. Gender shapes fertility desires and affects couples' ability to discuss and make informed decisions about contraception; it can also influence access to information and services. SDM is a user-directed and couple-focused method, and its successful use requires that a woman be able to effectively negotiate protected sexual intercourse or abstinence during her fertile days. Research has found that women whose partners are positively involved in SDM use are more likely to use the method correctly over a longer period of time. Formative research, pilot studies, and stakeholder interviews conducted by IRH identified several major barriers to SDM take up and use[55]. To facilitate uptake and correct use of SDM during scale-up, it was crucial that IRH and partners identify and address gender-related obstacles to method use. Several of IRH's specific approaches are described, followed by observations on their effects. These include applying a gender lens to communication efforts, providing capacity strengthening, advocating for engaging men as partners in FP programs, and expanding access to SDM beyond health facilities.

Gender-related Obstacles to SDM Uptake and Use

1. Opposition to FP use by male partners, rooted in cultural and religious beliefs about fertility and a lack of information about/ understanding of available methods.
2. Limited or no access to household resources, including transportation and income, limited women's ability to access SDM information and services.
3. Providers and stakeholders were biased regarding men's willingness to use SDM and women's ability to manage fertile days.
4. Gender norms prohibited some women from discussing sex or making decisions about birth timing and spacing.
5. Fear of violence impeded women's ability to negotiate timing and frequency of sexual intercourse.

[55] Lundgren, R., Cachan J., and Jennings V. "Engaging Men in Family Planning Services Delivery: Experiences Introducing the Standard Days Method® in Four Countries." *World Health & Population:* 14(1) October 2012: 44-51.

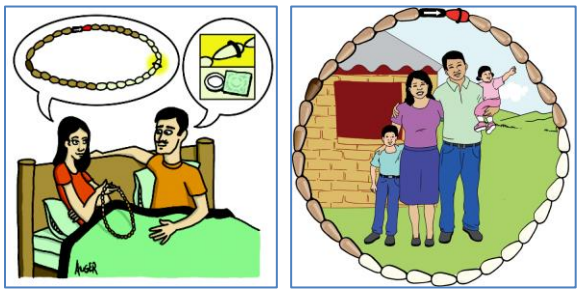
"Women know that they need family planning but the husband and/or mother-in-law don't always agree. The husband is the one in the family who makes decisions. Men decide if they want to have a baby or not and sometimes the woman feels that she is in danger from her husband if she refuses [sex]. Then she may get pregnant."

Program Manager, Mali

Applying a gender lens to communication efforts

Demand-creation and information dissemination were described in Chapter 3.4.5; the topic is introduced again here to point out that a variety of communication strategies were employed to address gender norms and convey gender equitable messages about reproductive health and FP. Special efforts were made to reach men using appropriate messages and channels. Print materials included images of couples or families (and not only of women) and descriptions of how they used SDM (Figure 17). Materials showed couples receiving FP counseling, although in many countries women typically received FP counseling alone. The language in these materials highlighted the importance of using SDM as a couple.

Figure 17: Illustrations from SDM Instructions and Flyers in Guatemala



All five countries made use of mass media to disseminate information not only on FP and SDM, but on gender, birth spacing and couples communication. Radio programs that specifically targeted men were developed in India, Guatemala and Rwanda: male characters engaged in conversation about the advantages of FP and dialog between spouses, the disadvantages of having too many children or too closely spaced pregnancies, and the impact that FP use can have on women's health and the family's budget. A radio program in Guatemala directly addressed domestic violence and national laws against it.

Facilitated discussions in same-sex groups were used in some countries. In Mali, for example, men's associations and religious groups frequented by men were a platform for message dissemination and dialogue. In India, meanwhile, IRH used street theater in places frequented by men; in Guatemala, dramas were staged at motor-taxi hubs.

Building the capacity of providers to engage men and couples

IRH and partners realized that it was not enough to train providers on the technical elements of SDM. Providers also had to learn to engage men in counseling and help women address couple-related issues that supported or constrained method use. Within each country, training curricula included modules (Table 24) to train providers to address gender-related obstacles, including key questions to ask during counseling. For example, providers were taught to help women assess whether they could refuse unprotected sex during the fertile days, and how to discuss FP and SDM with their partner.

Table 24: Training Topics to Strengthen Male Involvement

	Messages and themes
Building the capacity of providers	Sexual and reproductive health rights, sexuality and gender Strategies to engage men in services and counseling How to support couple communication for FP use
Key messages for provider counseling	Encourage women to share information with their partner or spouse Help women and couples develop a plan to manage fertile days Discuss ways that men can participate in FP use Screen for gender-based violence, alcohol use, HIV risk
Coordination with health centers	Build capacity of male and female providers Enhance access to FP by working with community-based providers and promoters

IRH also promoted a balance of male and female providers who were able to counsel on SDM. Most clinic-based providers who offered FP services were nurses and auxiliary nurses—positions typically held by women—so it was important that male providers be trained to offer SDM. In Mali, some clinic-based health workers (male and female) were identified as being particularly skilled in communication with men; these providers were on call for male clients at specific health centers.

Male health workers in Rwanda

Efforts to encourage providers to address couple issues during counseling had varied results across countries (Table 25). According to the results of provider interviews at midline/endline, the percentage of providers who discussed strategies to manage the fertile days during simulated counseling with the interviewer ranged from one third of providers in DRC to almost all (97%) providers in India. When asked to list criteria for method use, the percentage of providers who mentioned the ability to manage the fertile days ranged from 1% in Mali to 56% in India. There were similar differences across countries in the percentage of providers who spontaneously named male involvement as a positive characteristic of SDM, ranging from only 5% in Mali to 21% in DRC.

Table 25: How Providers Encourage Male Involvement in SDM Use

	DRC Midline (n=132)	India Endline (n=268)	Mali Midline (n=127)	Rwanda Midline (n=116)
Explains how to manage the fertile days during counseling during simulated counseling	32%	97%	90%	78%
Mentions the ability to manage the fertile days as criteria for use during simulated counseling	28%	56%	1%	16%
Considers that involving partner is a positive characteristic of SDM	21%	31%	5%	13%

Source: IRH Interviews with Providers

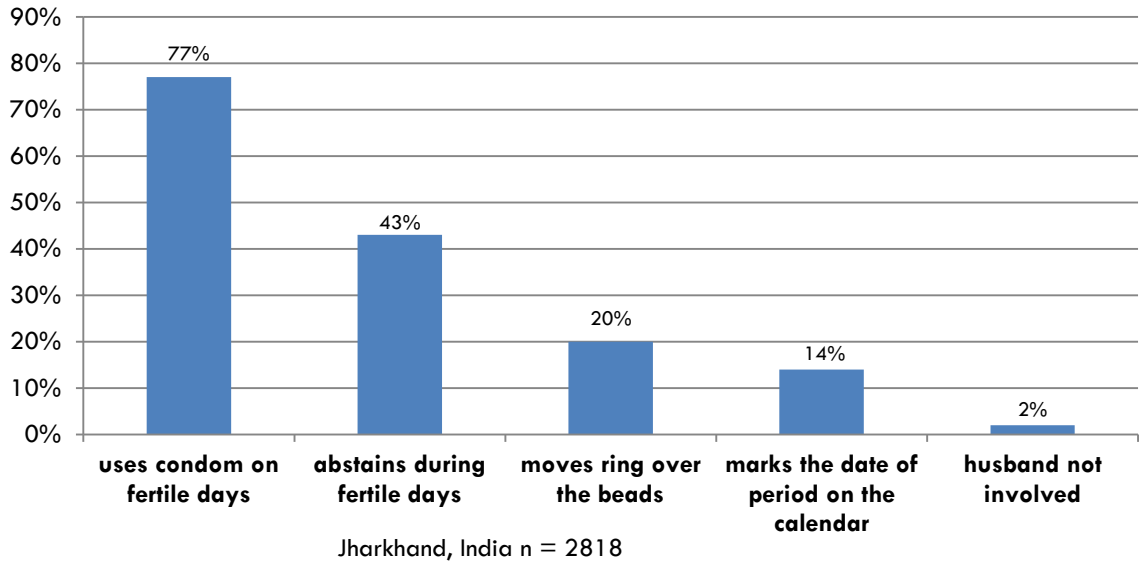
Evidence-based advocacy promoted male involvement in FP

Policy makers and health care providers often raised the concern that men would be unwilling or unable to use condoms or abstain from sex during fertile days. IRH used data from its SDM efficacy studies (conducted prior to the scale-up phase), which showed that only 2% of SDM users dropped out because of partner unwillingness to use the method.[56] Data from 14 studies in Latin America, Asia, and Africa found very few women who reported that their husbands insisted on sex during fertile days.[57] Data collected during scale-up corroborated these earlier findings.

Analysis of CFU results in India (Figure 18) confirmed that men were interested in SDM and participated in method use in several ways: using condoms or abstaining during fertile days, supporting partner's use of the method, keeping track of fertile days; and purchasing CycleBeads and condoms. Only 2% of women reported that their partners were not involved in their SDM use. Moreover, endline survey results in all countries indicated that few women discontinued SDM use due to partner issues – 4.5% of discontinuers mentioned that their partner disapproved of the method and 7% mentioned that the method required too many days of abstinence. IRH carefully documented findings from studies and scale-up monitoring, and disseminated them widely. Within the scale-up countries, the findings were useful for correcting misperceptions about male participation, and advocating for SDM inclusion in the method mix.

[56] Arévalo, M., Jennings, V., and Sinai, I. 2002. "Efficacy of a new method of family planning: the Standard Days Method." *Contraception:* (65) 333-338.
[57] Gribble, J.N., Lundgren, R., Velasquez, C., Anastasi, E. 2008. "Being strategic about contraceptive introduction: the experience of the Standard Days Method." *Contraception*: 77(3) 147-154.

Figure 18: Husband Support in Managing Fertile Days



Source: IRH Client Follow Up Data, Jharkhand, India

Expanding access to SDM offered opportunity to overcome gendered obstacles

IRH and partners' work to expand access to SDM by making it available via community and social-marketing channels was discussed above. This work improved equitable access, but it also helped overcome certain gender barriers. In many places, for example, restrictions on women's mobility prevented them from visiting health facilities. Men, meanwhile, were often not explicitly included in clinic-based FP programs and services; new outlets increased their access to the method.

Results of efforts to reduce gender barriers to SDM use

M&E data suggested that IRH and partner efforts to address gender-based obstacles contributed to greater awareness of SDM among men and greater provider recognition of the importance of male involvement. They expanded access to and use of SDM, and to the overall success of scale-up. Interviews with users suggested that women whose partners participated in method use were more likely to use the method correctly, and over a longer period. In addition, MSC stories often highlighted the benefits to users and programs of engaging men in FP services and use.

Although it is generally assumed that men are underserved by the health system, IRH's endline results suggested that health facilities were the most important source of information on SDM for men. Men who stated that they had heard of SDM were asked to name three sources of information. About one-third of men in DRC, India and Rwanda, and half of men in Guatemala, cited a health talk as their source of information about SDM. One quarter of men in Guatemala and Rwanda cited health facility posters. As expected, men mentioned media as an important source in all countries, ranging from 14% in Guatemala to 55% in Rwanda. With regards to the role of men in the diffusion of information on SDM, very few women reported their partner as a source of information on SDM, with the exception of DRC, where 18% of women heard of SDM from their husband.

Baseline and endline household survey data showed mixed success in reaching men with SDM information and services. In India, a significant increase was seen in the proportion of men who had ever heard of the method, from 3% at baseline to 42% at endline. Indian men's current use of SDM also rose from 0.3% to 7% of all family planning use. In Guatemala, on the other hand, the percentage of men aware of SDM remained statistically unchanged from baseline (27%) to endline (26%), and their current use remained under 1%. In Rwanda, where IRH used a mix of direct and indirect approaches to engaging men, the endline survey found that fully 88% of men were aware of SDM. Among these, 7% had ever used the method, and 5% of family planning users were current SDM users.

The endline survey results also reveal that male users had adequate information to use the method correctly, and that their level of knowledge was comparable to that of women. On a six-item scale that ranged from 0 to 1, men's knowledge score was .70, slightly below women's score of .72. This suggested that the strategies used to reach male users with information about how to use SDM were effective. Across countries most female users reported husband participation in SDM use. In addition to abstaining or using an alternate method on fertile days, husbands often moved the ring on CycleBeads, reminded their wife to do so, or marked the calendar. Table 26 presents information on male participation in SDM use, as reported by women and men from all countries (both baseline and endline).

Table 26: Male Participation in SDM Use, According to Women and Men (Current and Former Users, Baseline and Endline)

	Current Users		Former Users	
	Women (n=112)	**Men** (n=83)	**Women** (n=61)	**Men** (n=52)
Husbands who participate in SDM use in any way (%)	88.4	74.7	63.9	51.9
Type of participation (multiple responses allowed) (%)				Too few responses for meaningful analysis
Moves ring on CycleBeads	58.9	4.9	27.8	
Marks calendar	53.3	39.3	28.9	
Reminds wife to move ring	51.1	52.5	27.8	
Asks wife if they can have unprotected sex	20.0	36.1	2.8	
Does not have sex on fertile days	63.3	37.0	58.3	
Uses condom on fertile days	37.8	37.0	38.9	
Uses withdrawal on fertile days	34.4	54.3	5.6	
Buys condoms	43.3	9.8	13.9	
Follows instructions on how to use the method	17.8	29.5	2.8	

Overall, 88% of women and 75% of men currently using SDM reported male participation in method use. The percent of former users, both men and women, reporting husband participation was lower. However, it was not possible to calculate significance of the differences in husband participation between current and former users because the question was asked slightly differently. Still, the data indicated that husbands of current users were more helpful in method use than husbands of those who stopped using the method. Both female and male responses aligned on this point. These results should be interpreted with caution

"I feel good that my husband now understands how my body works. He pays attention to my suggestions and respects my wishes. For the first time he asks me if we can have intercourse. I am happy that he cares about me."

- Female SDM user, India

because former users may have had recall problems, and many former users did not respond to the questions (missing values).

IRH research into SDM's effects on gender-related phenomena such as couple communication and women's empowerment were positive: integrating SDM into FP programs could improve gender outcomes. In India, 90% of women using SDM reported increased affection, understanding and ability to discuss sex with partners[58]. In Guatemala, women reported a significant increase in their ability to care for their own health, refuse sex, and communicate with their partners after six months of SDM use[59]. In MSC stories, the most frequently mentioned positive changes by SDM users in all countries were partner involvement, better couple communication, and greater intimacy.

In sum, IRH experience with SDM scale-up demonstrated that it was important to focus explicitly on equity, gender, rights and how they were embedded in the innovation that was being taken to scale. During the complex, multi-faceted scale up process in each country, it was easy to lose sight of these values: they often felt abstract and were difficult to measure. Nor did all stakeholders embrace all values equally. Thus, it was important to: a) define the core values that had to be maintained during scale; b) link these core values to the guiding principles of the scale-up framework, remembering that they were to be applied at all stages of planning and decision-making; c) identify practical approaches for maintaining focus on these values as SDM was taken to scale; and d) monitor how values were implemented over time.

CHAPTER 4: CONCLUSIONS

IRH's goal for the SDM scale-up phase was to sustainably increase access to and use of SDM in five countries, and the overall purpose of the accompanying prospective case study was to describe the process and outcomes of SDM scale-up. As noted in Chapter 2.1, IRH developed a research hypothesis to manage the case study process and determine if the predictions inherent in the hypothesis were supported by the case study findings. This section discusses the evidence related to the hypothesis, stated below.

Hypothesis	**Applying a systems framework and scale-up principles will lead to wide availability of quality, sustainable SDM services**

[58] Institute for Reproductive Health, Georgetown University for the United States Agency for International Development. October 2005. *Introduction of the Standard Days Method® in CARE-India's Community-Based Reproductive Health Programs*. Washington, DC.

[59] Institute for Reproductive Health, Georgetown University for the United States Agency for International Development. February 2008. *Comparison of Standard Days Method® User Tools*. Washington, D.C.

Analysis of data from the five scale-up countries showed that application of a systems approach helped IRH approach the scale up challenge differently from how scale-up is frequently done, which often focuses on integration into norms accompanied by wide-scale training of health workers.

The ExpandNet framework, and the systems approach it embodied, helped IRH and partners balance the work of vertical and horizontal scale up. It reminded all parties that scale-up was more than geographic expansion, and helped resource teams understand how best to plan and manage concurrent work along the horizontal and vertical axes. This sometimes meant rejecting opportunities with short-term yields (for example, declining MOH requests to conduct provider trainings, and instead waiting until the MOH could fund and conduct these trainings itself with IRH assistance), even as it ensured that SDM was appropriately institutionalized.

The systems approach and guiding principles reminded IRH that scale-up was a multi-partner effort, requiring the participation of many actors whose work needed careful coordination. It also helped the resource team monitor and respond to the many macro environmental, institutional, political, and policy forces influencing scale-up. It emphasized that systems were not static: regular monitoring was needed to detect setbacks and opportunities for advances.

The ExpandNet framework broke the complex scale-up process into components that could be more easily understood and acted upon. It positioned SDM scale-up as an end in itself but also as a means to strengthen aspects of entire national (or subnational) health systems, and specifically FP programs. The framework provided a conceptual roadmap for planning, monitoring, and guiding decision-making; it offered a common vocabulary and visual tool to the multiple actors who contributed to scale-up.

Finally, within each scale-up country, the framework guided IRH and partners to 'start with the end in mind,' and to identify goals and benchmarks, develop indicators, and analyze M&E data as the resource teams progressed towards sustainable scale-up. Select benchmark indicators and achievements in each country are presented in Table 27.

Table 27: Selected benchmark indicators of horizontal and vertical scale-up achieved

SDM...	DRC	Guatemala	India	Mali	Rwanda
Is available in what percent of zones planned	98.3	99.0	90.5	96.4	103.9
If offered by what percent of trained providers planned	53.9	109.1	78.6	88.7	138.4
Is written into key norms & procedures documents	Yes	Yes	Yes	Yes	Yes
Is in nurse / CHW training curricula and supervision forms	Yes	Yes	Yes	Yes	Yes
Has its own reporting line in MOH HMIS	Yes	In process	Not yet	Yes	Yes
Is in logistics systems inventory and distribution forms	Yes	In process	Yes	Yes	Yes
Is in donor and/or MOH procurement tables	Yes	Not yet	Not yet	Yes	Yes

Collated from Tables 5 and 6, Chapter 3

The shift from researching and introducing an innovation to scaling up an innovation required staff to taken on a new perspective and acquire new skills in technical assistance. The systems approach helped

IRH staff understand and act upon the need to *create* capacity, rather than *be* the capacity, in training, advocacy, procurement, supervision and other areas. In other words, while staff initially saw themselves as trainers, experts, and advocates, they shifted to being mentors and colleagues who supported others in both technical and political areas.

As scale-up progressed, the evolving nature of IRH technical assistance, and how it varied from country to country depending on the maturity of the scale-up process, became clear. Early scale-up activities included adapting materials and curricula and training trainers. Other resource organizations took over these jobs as their capacity grew, while IRH transitioned into quality assurance and system integration.

Embracing the systems approach and these changing roles meant giving up full control of the scale-up process. During pilot studies and introduction of SDM, IRH staff generally had significant control over tasks, objectives, monitoring and process management. During scale-up, on the other hand, these functions were necessarily transferred to others. The advocacy, mentoring, and 'letting go' necessary for sustainable scale-up required not only new skills, but the patience and persistence to constantly monitor and address environmental changes and their effect on scale-up.

ExpandNet's guiding principles, and the core values embedded in SDM itself, proved more than theoretical. Rather, they advanced the scale-up process. Operationalizing and applying them throughout the scale-up phase created new opportunities and new partnerships. Most notable of these were collaborations with FBOs, which were often eager and able to play an important role in national FP programs. The SDM innovation package included tools such as those for quality assurance (KIT and CFU) that in some cases were used to improve FP provision as a whole. A focus on gender and reproductive rights also involved men in and increased couple communication about FP overall, and helped strengthen client-centered, multi-method programs. Making equity a priority meant that IRH and partners reached underserved populations and drove the expansion of SDM provision beyond facilities, through non-clinical delivery channels including community health workers, FBO-managed family counseling services, private pharmacies and retail outlets, and non-health organizations.

APPENDICES

Appendix A: The Prospective Case Study's Research Questions

Case Study Objectives and Research Questions

Objective 1: To compare and contrast similarities and differences in the innovation and the process and outcomes of SDM scale-up across countries.

Research Questions:

- What are the similarities and differences in the innovation and the process and outcomes of SDM scale-up across countries?
- Did different countries define innovation differently?
- How was the innovation simplified? What is the evidence that simplification worked?
- Why were benchmarks achieved or not achieved?
- What were differences between countries in the process and outcomes of SDM scale-up?
- How far is SDM along the road to high-quality, sustainable SDM services? Why does this differ across countries?

Objective 2: To assess the usefulness of applying the ExpandNet framework (a systems approach) to scale-up.

Research Questions:

- How useful was application of a systems approach (the ExpandNet framework) to the scale-up process? To what extent was the ExpandNet framework used at the headquarters and country levels?
- To what extent were scale-up principles applied (systems, evidence-based, rights oriented, quality, participatory)? To what effect?

Objective 3: To identify promising practices and key determinants of scale-up (facilitating and constraining factors), using ExpandNet as an organizing framework.

Research Questions:

- To what extent did user organizations assume the roles, responsibilities, and ownership of the resource team during the scale-up process?
- How did the roles of leaders develop and change during the scale-up process?
- How did key actor networks, both formal and in formal, change during the scale-up process? How did this affect scale-up?
- What was the relative balance of vertical and horizontal scale-up?
- What capacity building approaches were most effective?
- What skills and activities are needed to make scale-up happen?
- How does the strength of health systems, including support sub systems (HMIS, supervision, training, other), affect the scale-up process? Can scale-up be accomplished in weak systems?

- What did IRH do to advocate for SDM scale-up and what was the effect of that?
- To what degree was there multiple stakeholder involvement and partnership in SDM scale-up? What was the impact?
- What was the role of champions in SDM scale-up?
- What role do provider attitudes play in SDM scale-up? What has worked and not worked in addressing provider bias?
- What demand creation strategies, activities, and resources, were used? What were the most effective demand creation strategies?
- What progress has been made in integrating CycleBeads into the procurement systems of each country? What were the challenges and facilitating factors that affected progress?
- How did the procurement situation in each country affect scale-up?
- What are lessons learned and best practices for resource mobilization?
- How did each country develop benchmarks and operationalize scale-up?
- How was data used for decision making and quality improvement during the scale-up process?
- What lessons were learned about monitoring and evaluating of scale-up?

Objective 4: To describe the unique contributions of SDM scale-up to reproductive health at the organizational and individual level.

Research Questions:

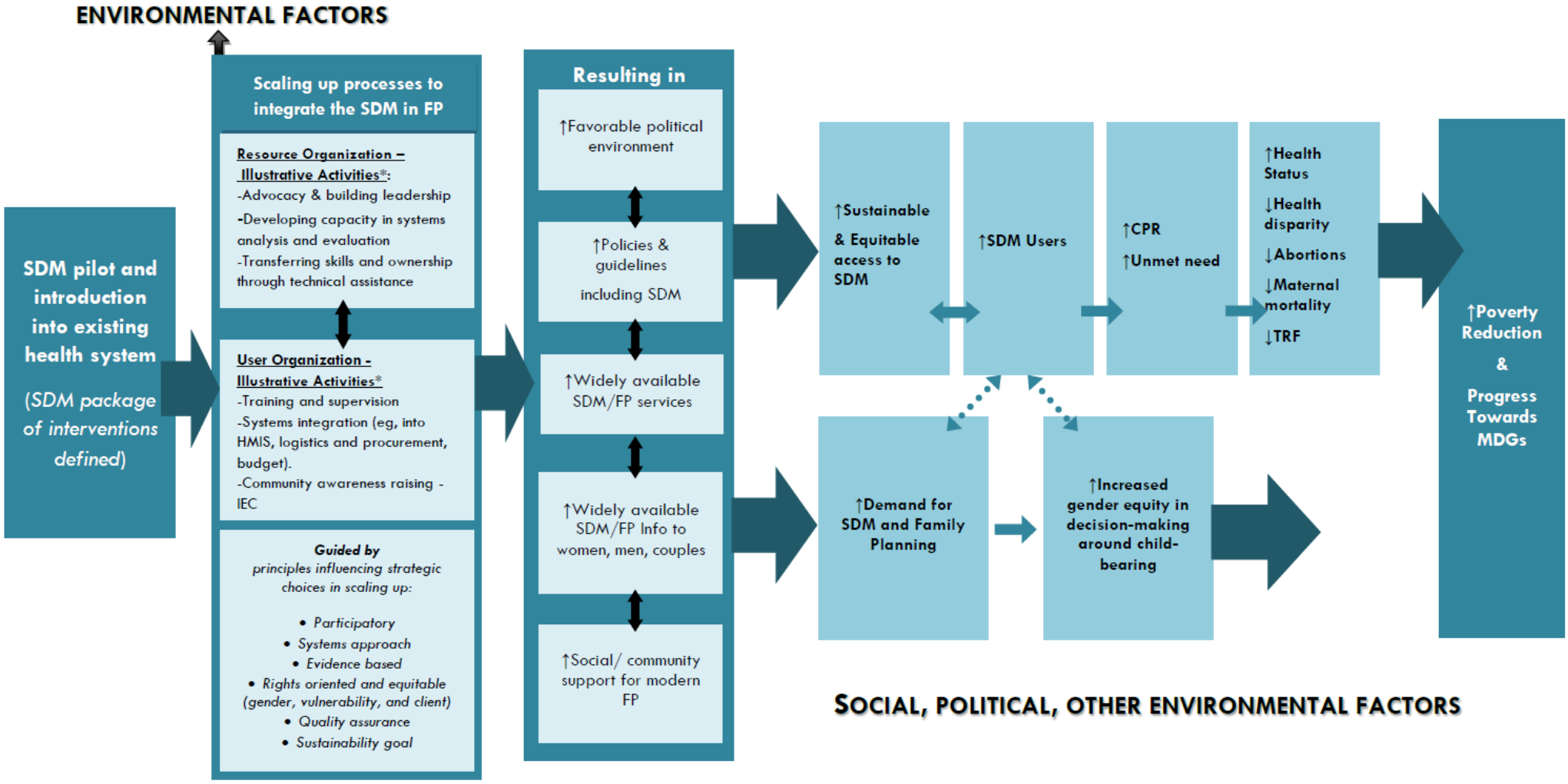
- What was the role and influence of religious organizations in SDM scale-up?
- Did SDM scale-up facilitate engagement of religious organizations/FBOs in national reproductive health agendas?
- To what extent has SDM been offered outside facility-based services?
- What were the factors that facilitated and limited scale-up outside of health facilities?
- In what ways was a gender perspective integrated into SDM scale-up?
- What indicators were used to measure gender?
- How do you integrate gender into a FP project and measure it?
- How did IRH address gender as a key value in SDM scale-up?

Objective 5: To identify the facilitating and constraining factors specific to SDM scale-up

Research Questions:

- To what extent did global forces, including donor priorities, affect country-level scale-up of SDM?
- What were the political motivations of stakeholders in scale-up of FAM? How did these affect the scale-up process?
- How did political and other factors in each country affect scale-up?

Appendix B: Relational Framework of SDM Integration into National FP/Development Programs



**The ExpandNet terms for scale-up are used for this framework. The arrow between the user and resource organization shows the fluidity between the two; organizations may move from user to resource or activities may switch around between user and resource organization, especially as countries go further along in the process of scale-up. Likewise, various results influence each other and shift throughout the scaling up process.*

Appendix C: Logic Model for Monitoring Performance and Evaluating FAM Scale-Up at the Country/Global Level

Table C.1: Logic Model for Monitoring Performance and Evaluating FAM Scale-Up at the Country Level
In-Country Program Perspective: What IRH and its network of in-country partners are collectively responsible and accountable for
Objective: Reduce unmet need by increasing FAM use

INPUTS	PROCESS Activities Participation		OUTPUTS/OUTCOMES		
What we invest	***What the program does***	***Who is reached***	***Short-term changes***	***Medium term changes***	***Long-term changes***

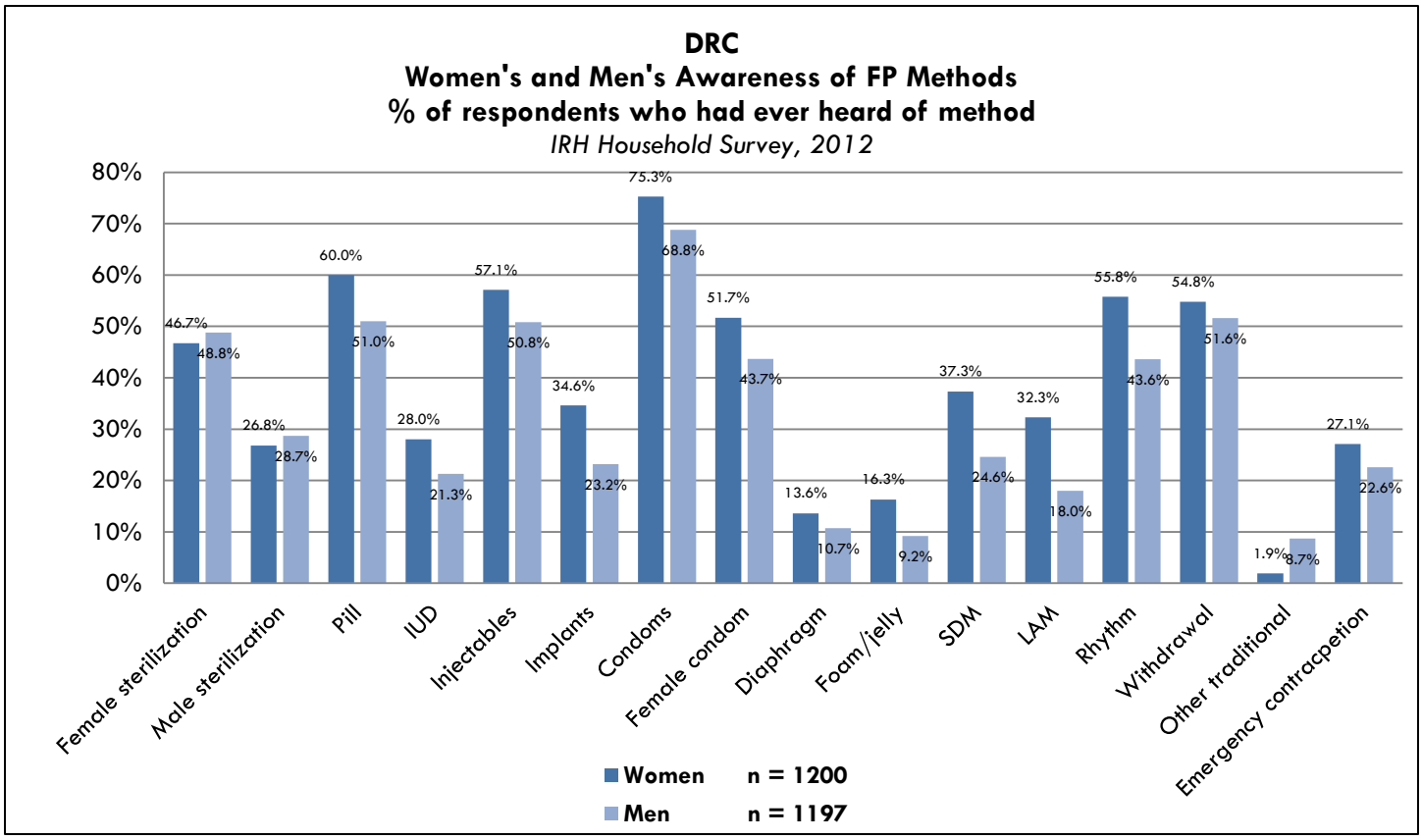
• Staff (IRH and partners)
• Trainers
• Supervisors
• Time
• Financial resources
  o IRH
  o Others
• Research Findings
• In-country FAM resource organizations
• Partners (global and in-country)
• Policy Guidelines and procedures
• FAM resources
  o Training materials
  o IEC materials
  o Supplies (ie, CycleBeads and client instructions)
	• Provide technical assistance
	• Advocate for integration of FAM into service delivery
	• Develop/adapt /disseminate IEC materials
	• Create awareness in potential users (dissemination of IEC messages)
	• Provide FAM support services (MIS, procurement, etc.)
	• Train providers
	• Supervise service delivery
	• Training of trainers
		• Potential FAM clients
		• Other FAM stakeholders
		• Community members
		• Policy makers
		• Training Institutions
		• Students (medical, nursing, etc.)
		• FP providers:
		  o Community health workers
		  o Private FP practitioners
		  o Commercial outlets
		• Program and clinic managers
			• Increased awareness of fertility and FAM
			• FAM integrated into existing FP programs (national, sub-national organizations): Policies and norms, IEC, MIS/reporting, national surveys, procurement, training programs, supervision systems
			• Trained providers
			• Service delivery systems (public, private practitioners and commercial outlets) provide FAM
				• Improved attitudes towards FAM (among policy makers, providers, donors and clients)
				• Increased demand for FAM
				• FAM services sustainably included in RH systems
				• Increased provider competence
				• Increased fertility knowledge
				• Increased use of FAM
					• Reduced unmet need

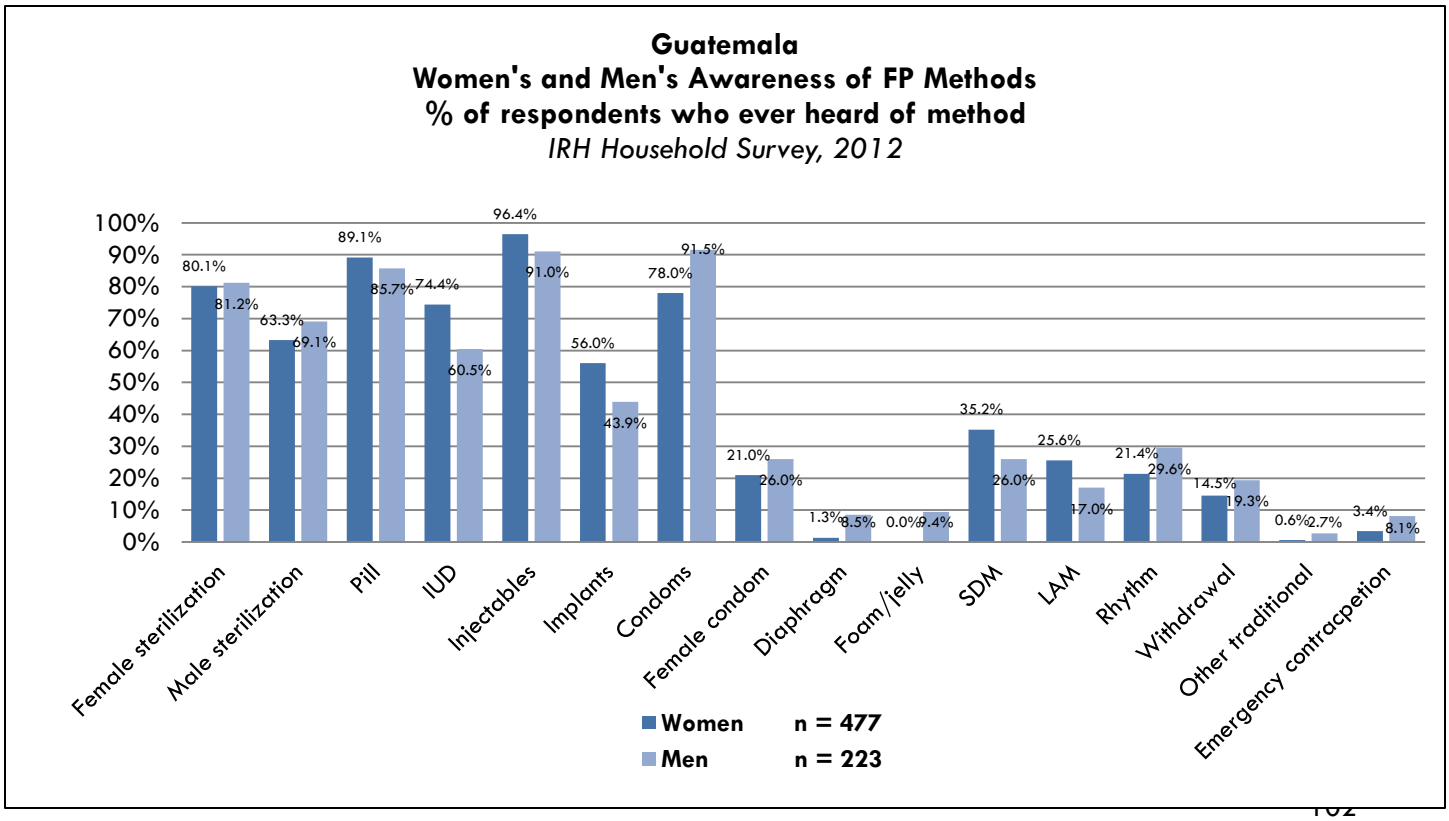
Input/Resource Monitoring	**Input/Resource Monitoring**		**Outputs Monitoring/Outcomes Monitoring**		
Evaluation on process, systems strengthening, and outcomes					

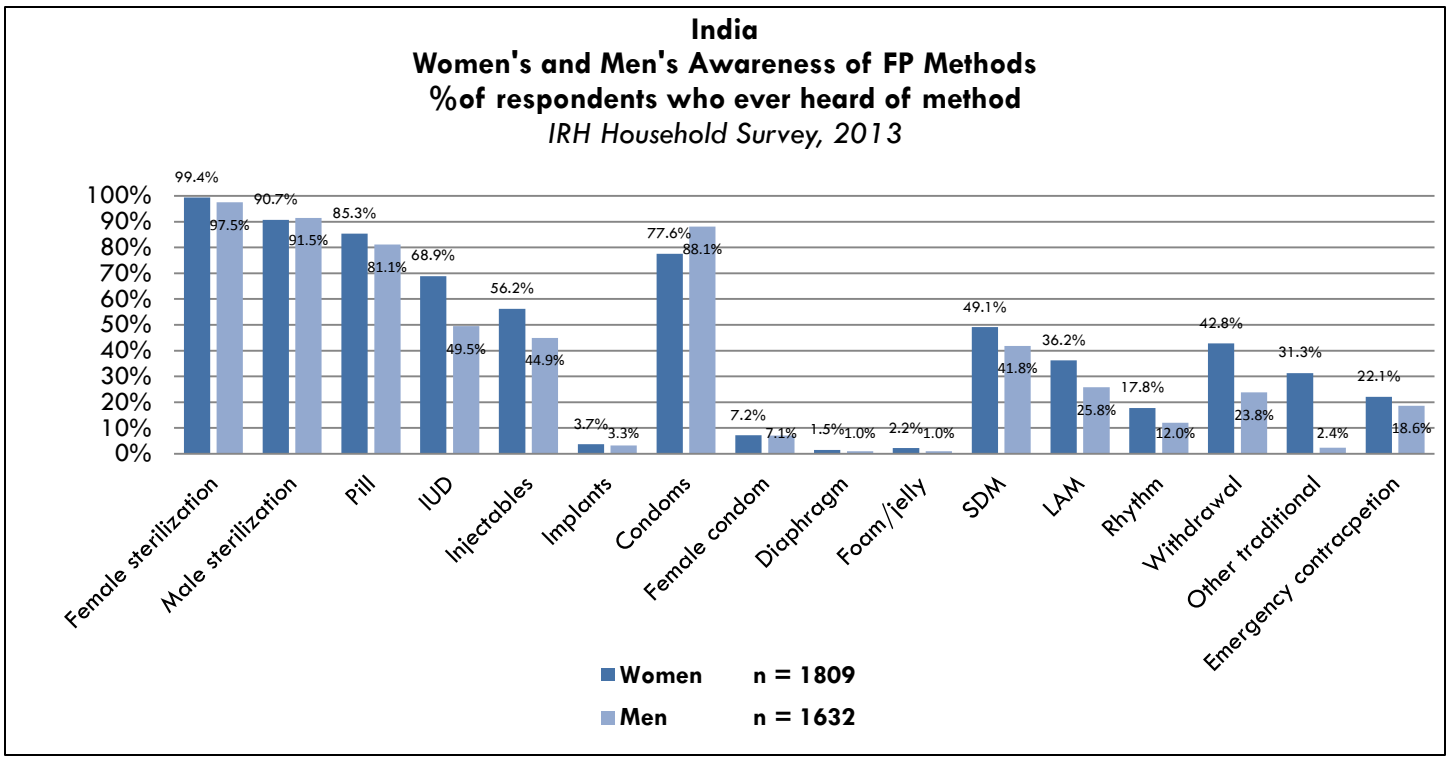
Table C.2: Logic Model for Monitoring Performance and Evaluating FAM Scale-Up at the Global Level
Global Project Perspective: What IRH and its technical partners are responsible and accountable for
Objective: Expand family planning choices by making FAM available

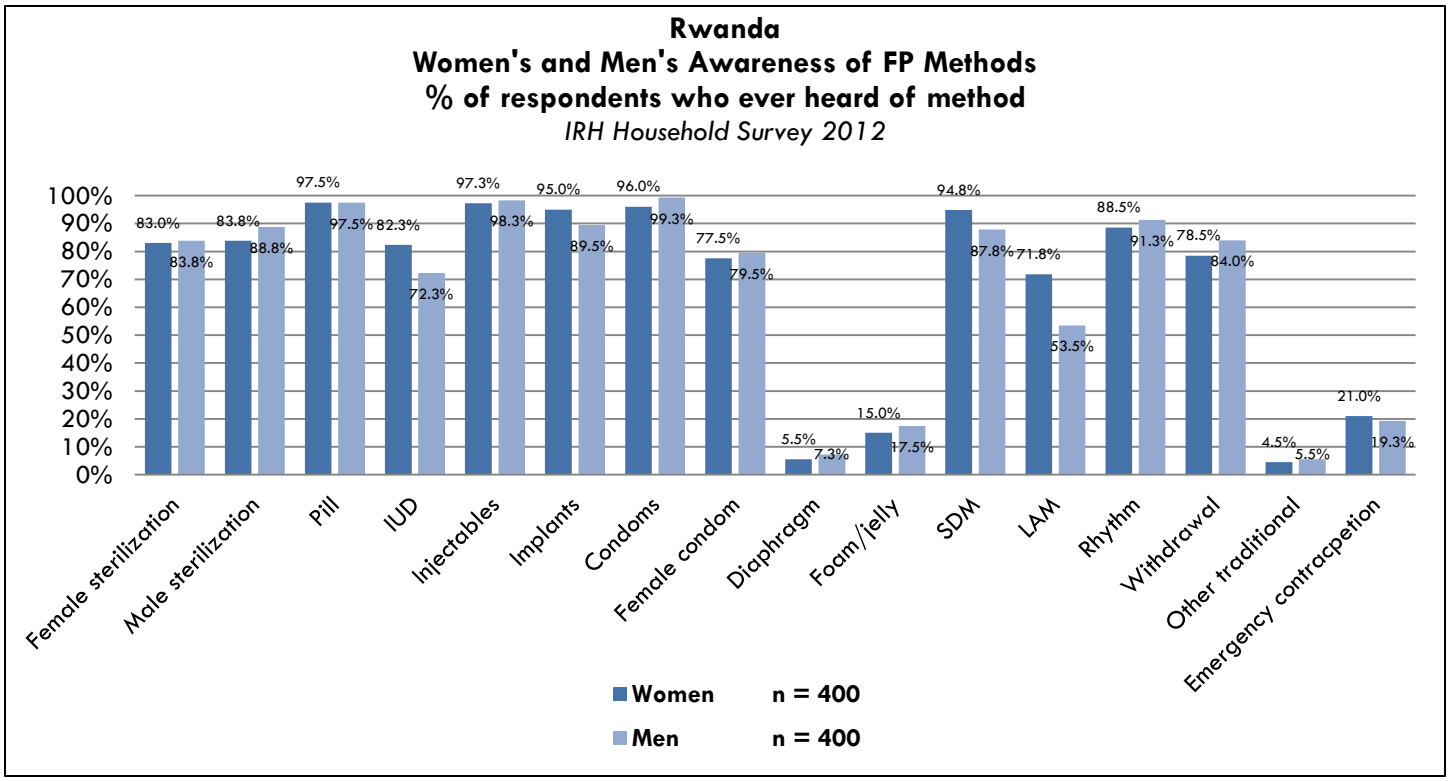
INPUTS	PROCESS Activities Participation		OUTPUTS/OUTCOMES		
What we invest	***What the project does***	***Who is reached***	***Short-term changes***	***Medium term changes***	***Long-term changes***
• Staff: o Technical o Management o Support • Technical Partners • Time • Financial Resources o USAID/W o USAID/Missions • Knowledge	• Conduct and disseminate research • Advocate for FAM Integration (MIS, policy procurement, etc.) • Engage/expand and maintain partners • Mentor in-country resource organizations • Provide Technical Assistance o *Strategic Planning* o *Quality Assurance* o *Monitoring and Evaluation* • Develop/adapt training resources • Train trainers • Develop, adapt, and disseminate IEC resources • Procure supplies	• Partners (Global and In-country) • Host governments (national, regional other) • Policy makers • Donors including USAID Missions • Pre-service training Institutions • Research institutions • Community leaders • In-country FAM resource Organizations • Other FAM stakeholders	• Research findings available • Partnership with FAM resource organizations strengthened • Diverse partners • Sensitized policy makers and partners • Coordinated vision for FAM scale-up • FAM integrated into existing FP national and organizational programs: Policies and norms, IEC, MIS/reporting, national surveys, procurement, training programs, supervision systems • FAM training resources available • FAM trained trainers available • FAM IEC resources available • FAM supplies available in public, private and commercial outlets • Strengthened research capacity	• Research findings utilized • Increased capacity of FAM resource organizations to provide FAM technical services • Increased stakeholder awareness of FAM • Broadened base of support • Improved capacity of governments, partners and commercial outlets to provide FAM • Improved services by addition of FAM	• Increased availability of FAM
Input/Resource Monitoring	**Input/Resource Monitoring**		**Outputs Monitoring/Outcomes Monitoring**		
Evaluation on process, systems strengthening, and outcomes					

Appendix D: Men's and Women's Knowledge of FP Methods






India
Women's and Men's Awareness of FP Methods
%of respondents who ever heard of method
IRH Household Survey, 2013
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
99.4%
97.5%
90.7%
91.5%
85.3%
81.1%
68.9%
49.5%
56.2%
44.9%
3.7%
3.3%
77.6%
88.1%
7.2%
7.1%
1.5%
1.0%
2.2%
1.0%
49.1%
41.8%
36.2%
25.8%
17.8%
12.0%
42.8%
23.8%
31.3%
2.4%
22.1%
18.6%
Female sterilization
Male sterilization
Pill
IUD
Injectables
Implants
Condoms
Female condom
Diaphragm
Foam/jelly
SDM
LAM
Rhythm
Withdrawal
Other traditional
Emergency contracpetion
Women n = 1809
Men n = 1632


Rwanda
Women's and Men's Awareness of FP Methods
% of respondents who ever heard of method
IRH Household Survey 2012
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
83.0%
83.8%
83.8%
88.8%
97.5%
97.5%
82.3%
72.3%
97.3%
98.3%
95.0%
89.5%
96.0%
99.3%
77.5%
79.5%
5.5%
7.3%
15.0%
17.5%
94.8%
87.8%
71.8%
53.5%
88.5%
91.3%
78.5%
84.0%
4.5%
5.5%
21.0%
19.3%
Female sterilization
Male sterilization
Pill
IUD
Injectables
Implants
Condoms
Female condom
Diaphragm
Foam/jelly
SDM
LAM
Rhythm
Withdrawal
Other traditional
Emergency contracpetion
Women n = 400
Men n = 400

Appendix E: Selected Components of the Innovation and Simplification for Scale-Up

Components of the innovation	Description of components	Change or simplification to the innovation	Justification for change or simplification of the innovation
Standard Days Method (SDM) and Lactational Amenorrhea Method (LAM)	Family planning method protocol and eligibility criteria for SDM and LAM.	In the original counseling protocol, method screening called for an arithmetical calculation of cycle length to determine eligibility but in the revised protocol, the cycle length calculation was dropped and replaced with cycle length estimation.	In 2009, according to results of the SDM Screening Study, IRH revised criteria for user eligibility during counseling so that women with periods about a month apart could begin to use the method instead of requiring women to calculate the exact length of their cycle to ensure cycles were in the 26-32-day range. The simplification of the counseling protocol was **credible** in that it was based on the results of a study and it was proven that simplifying the screening protocol, the innovation would be **easy to install and understand**.
Product: CycleBeads	The product consists of the CycleBeads, including the packaging, and the instructional insert.	The format and content of the insert was simplified. The booklet was changed to a foldout and a 4-year calendar was added. The instructions in the insert were simplified and more images were added.	The inclusion of a four-year calendar in the insert makes the modified innovation **easier to install** because there is no need to resupply calendars every year to existing users of CycleBeads thus **enhancing scalability**. Changing the booklet to a foldout allowed the insert to be more visual and less text-based; it was then used as a counseling tool and memory aid by providers. By simplifying the text in the insert and making images clearer, the innovation takes into account the section of the population with a low literacy level, thus increasing the **compatibility** of the innovation with the literacy level of the population. By simplifying the instructions on the insert, SDM/CycleBeads could be used by a person without provider counseling and so was ready to be offered through the private sector, e.g. in pharmacies. The insert also became a counseling aid for providers.
Monitoring and Evaluation/Quality Assurance	"Knowledge Improvement Tool (KIT)," a checklist to verify provider knowledge, used for quality assurance.	SDM KIT geared towards clinic-level providers, based on counseling protocol used in pilot study, during scale-up the KIT was shortened and simplified.	The SDM KIT was simplified and shortened so as to adapt for all providers, not just clinic-based. This improved **compatibility** so that the KIT could be used with community-level workers.

Components of the innovation	Description of components	Change or simplification to the innovation	Justification for change or simplification of the innovation
SDM Training Modules	Training modules for: general SDM training, pre-service training, in-service training, cascade trainings, distance learning	The total time for SDM training decreased and the manual was modified to reflect this change.	During the AWARENESS project, the SDM training module took up to 5 days, but during FAM SDM training was incorporated into standard trainings on all FP methods, and SDM-specific training was reduced to a couple of hours or up to one day depending on the context and audience. This change made the innovation **compatible**.
		Cascade training	IRH designed the cascade TOT model where providers were trained to provide SDM training to staff at their facilities because it was not feasible to invest major resources in centralized training approaches. The cascade TOT model helped transfer capacity and promote SDM; it was an efficient way to address training needs and **enhanced scalability** of the innovation.
		Training for community-based distribution of FP, including SDM/CycleBeads, by community health workers.	In all focus countries SDM was seen as a method that could be offered in geographically isolated or underserved communities so training strategies and provider materials, such as provider counseling aids, were adapted so that non-clinic providers, such as CHWs or midwives, could offer SDM. The community-based distribution and training of community health workers made the innovation more **compatible** with the realities of the countries and **enhanced scalability** of the innovation because CHWs were able to reach isolated communities.
		SDM training participant handouts & counseling aids	When the insert was modified, one product served the dual purpose of training handout and counseling aid, thus increasing **ease of transfer**.
IEC strategies and materials	Awareness raising materials and strategies	Materials were developed to increase knowledge of methods, dispel rumors about FP, etc. When the FAM project started, materials were mostly clinic and print media focused, using CBs insert and posters.	New materials and strategies were developed for demand creation purposes. Demand creation materials were geared towards clients and providers in both private and public clinics in the local languages. In the beginning of the scale-up process, countries relied mostly on print media. As scale-up progressed, it was clear that, based on facility assessment and data collected, more diverse demand creation activities needed to be carried out in order to increase knowledge of SDM. Different media, such as radio or TV, were tested and implemented. IEC materials always promoted informed choice and information on all methods, with a special focus on SDM. All countries had a social marketing aspect to their demand creation activities.

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