PROMISING PRACTICES FOR SCALE-UP:

A Prospective Case Study of Standard Days Method® Integration

FAM PROJECT

IRH GEORGETOWN UNIVERSITY

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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.[1] 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.*[2] 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.

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. Results of these studies suggested that SDM merited scale-up for a number of reasons (see box). In 2007, with USAID support for adding a simple, modern, natural family planning (NFP) 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[3] 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.

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/

[1] 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)]

[2] Definition from WHO/ExpandNet, with minor modifications

[3] www.expandnet.net

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, 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.

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, 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
- # of logistics systems that include SDM
- # of HMIS/reporting systems that include SDM
- # of IEC activities/materials that include SDM
- # of national surveys that include SDM as a unique category

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.

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 percent of Jharkhand districts with the greatest need for family planning services.

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

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 (81%) learned about the method from television.

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		

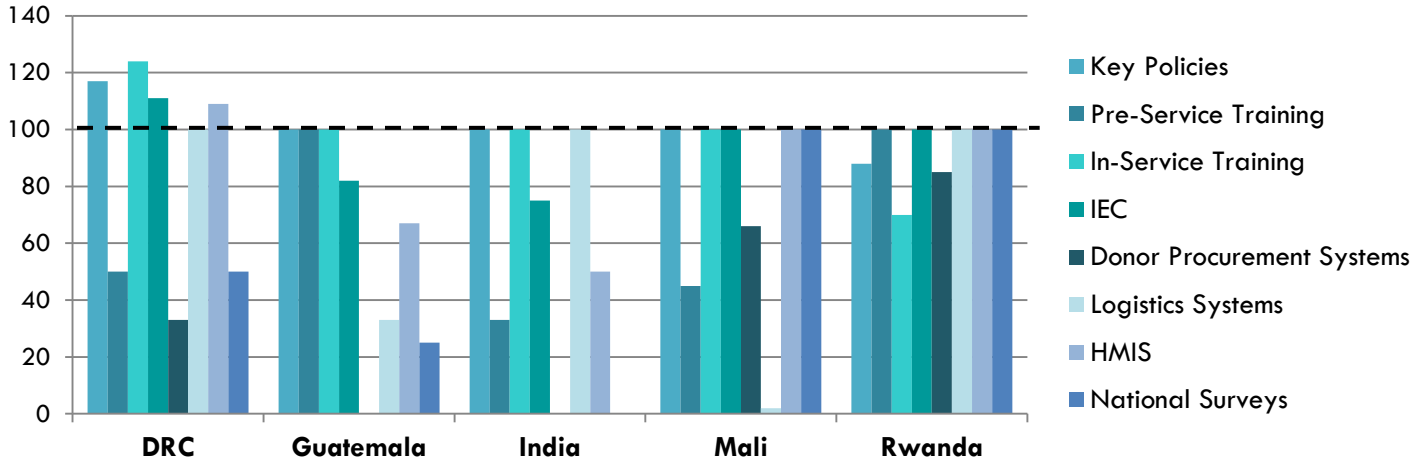
All survey respondents who had heard of SDM were asked their opinion about the method. Of the women who had heard of SDM but had never used it, 51% considered it effective in preventing pregnancy and 52% thought it would be easy to use. In contrast, these figures were 89% and 85% respectively for women 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 (74%) who were using the method at the time of the survey were satisfied with it, and 79% were planning to continue using it.

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).

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)						

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.

VERTICAL SCALE-UP ACHIEVEMENTS AGAINST COUNTRY-SPECIFIC TARGETS (%)



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 SDM into some of the government and donor procurement systems and secure their financial commitment to purchase CycleBeads. 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

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.

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.[4] 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 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.

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.

[4] [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]

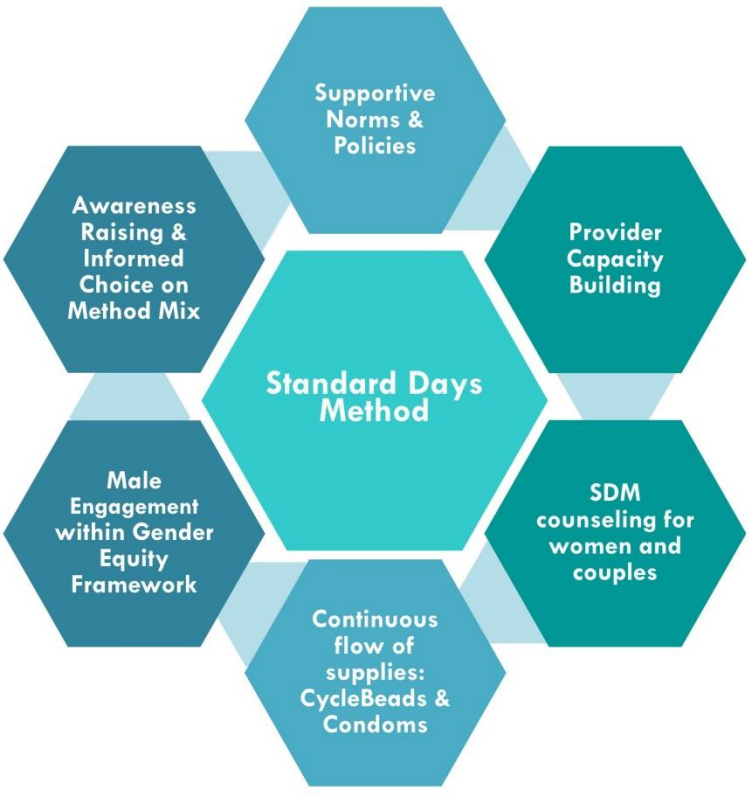
LESSONS LEARNEDABOUT SCALE-UP

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.

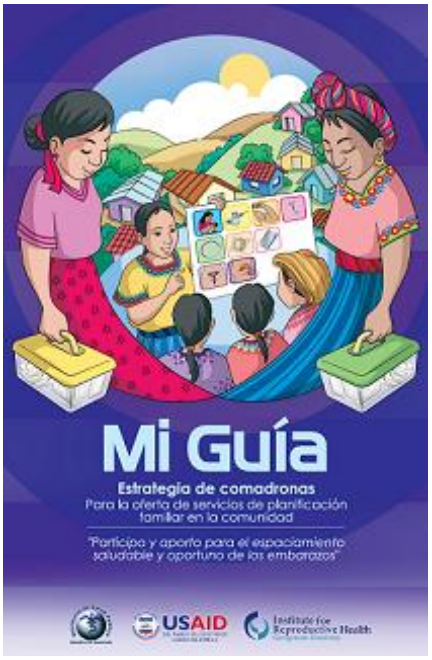
Scale-up as opportunity to strengthen health systems: In all countries, the primary user organization was the MOH (and in some cases related ministries). Governmental health systems generally needed strengthening and lacked the infrastructure, expertise and human resources to do the work of scale-up. 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 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.



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.

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 3* - 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 Fecundite*, 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

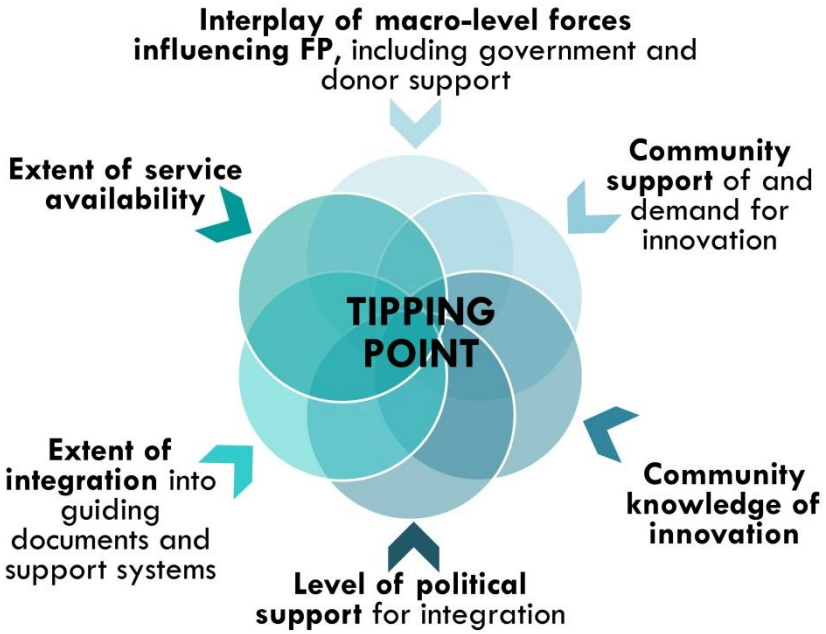
mission to a very challenging one. Consistent support in some missions, on the other hand, greatly contributed to scale-up success.

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 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

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 above 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.

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 its 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.

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