SCALE-UP OF STANDARD DAYS METHOD® IN GUATEMALA

COUNTRY BRIEF

USAID FROM THE AMERICAN PEOPLE

FAM PROJECT
IRH GEORGETOWN UNIVERSITY

Since the early 2000s, the Institute for Reproductive Health at Georgetown University (IRH) has introduced and tested the Standard Days Method® (SDM) in a variety of service delivery settings around the world. IRH and partners are now scaling up SDM services in family planning (FP) programs in the Democratic Republic of Congo, Guatemala, India, Mali, and Rwanda. This report summarizes events in Guatemala, including choices, approaches and results of systematic SDM scale-up and related research. It concludes with an analysis of factors that influenced scale- up.

The Ministry of Health (MOH) is the largest health service provider in Guatemala, followed by the Social Security Institute (IGSS) and the NGO, APROFAM. The MOH's third-tier facilities are typically found in remote, rural areas and staffed by trained community volunteers, an auxiliary nurse and perhaps a rural health technician. Second-tier facilities are health centers offering mostly outpatient services, while first-tier facilities are regional and national hospitals. Access to services remains a significant problem for the rural poor, although the government has made progress via a special program designed to reduce disparities in health services and outcomes between ladino and indigenous Guatemalans.

The government of Guatemala has supported family planning programming for about three decades, and the overall contraceptive prevalence rate, for all methods, among women of reproductive age is currently 54%. However, there are a variety of factors, including politics, cultural diversity, and religion, which influence access to and use of family planning in the country. For example, the Catholic Church exerts a strong political influence and has opposed enactment of the *Law on Universal and Equal Access to Family Planning Services.* Given the church's preference for natural methods of family planning, the institution's clout would be expected to create an enabling environment for SDM integration. However, certain sectors of the Catholic Church oppose SDM because it is not based on checking physical signs of fertility and promotes the use of a barrier method during fertile days. On the other hand, certain cultural factors facilitated SDM scale-up in the country. Some Mayan cultures believe that foreign items such as modern contraceptive methods upset the spirit-body balance and can cause ill health, and see SDM as a family planning method that is acceptable.

Map: Adapted from UNICEF

GUATEMALA AT-A-GLANCE

CURRENT POPULATION:	14.7 million
POPULATION GROWTH RATE:	2.52% per year
GDP PER CAPITA, 2012:	$3,178
INDIGENOUS POPULATION:	41%
INDIGENOUS POPULATION BELOW POVERTY LINE:	74%
TOTAL FERTILITY RATE:	3.9
CONTRACEPTIVE PREVALENCE, WOMEN AGES 15-49, 2009:	54.1%
MATERNAL MORTALITY RATIO PER 100,000 LIVE BIRTHS:	140
INFANT MORTALITY RATE PER 1,000 LIVE BIRTHS:	24.2

Sources: World Bank World Development Indicators, Guatemala DHS

INTRODUCTORY PHASE 2002-2007

Among its first steps in Guatemala, IRH established the evidence-base for integrating SDM and ensured its inclusion in the national norms. IRH then worked with USAID partners, the MOH and local NGOs to integrate SDM into public and private sector FP services in five departments (of 22 total in Guatemala) that are home to rural, indigenous populations.

IRH set several objectives for its pilot phase in Guatemala, noted below with information about their achievement:

- *Integrate SDM into public and private programs and ensure quality services.* With SDM securely included in national norms, IRH worked with the public and private sectors (including NGOs and FBOs) to build capacity for SDM counseling, raise awareness of the method, and strengthen service provision through research. IRH and USAID partners developed SDM training and IEC materials; these and several other NGOs then conducted SDM training for the MOH, IGSS and still other NGOs that provided FP services.

- *Test/document various strategies for provision*. At the MOH's request, and based on its concern that CycleBeads®' cost would discourage potential users, IRH developed a paper image of CycleBeads. Use of the paper image was compared to use of actual CycleBeads with 600 SDM users and 90 providers over 18 months. Users and providers preferred the real beads, though users performed equally well with the paper version.

- *Develop and test a cost-effective, distance learning module.* IRH created a distance-learning module with two formats (online and self-study), tested it with 120 auxiliary nurses, and found that both formats were acceptable and effective.

- *Evaluate cost-effectiveness of the Knowledge Improvement Tool (KIT) as a supervision tool.* In Guatemala, IRH found that KIT was most cost-effective when used in a group (rather than one-on-one) to reinforce provider knowledge of SDM.

- *Include SDM in nurse and auxiliary nurse pre-service training.* IRH succeeded in introducing SDM into the training curricula of MOH nursing programs. At the close of the pilot phase in 2007, SDM was embedded in national FP norms, and some headway had been made to include the method in national management information and logistics systems, pre- and in-service training, and communication strategies. About 200 trainers and 2,000 providers knew how to offer the method.

PILOT PHASE ACHIEVEMENTS

- SDM integrated into public and private programs in five departments
- Strategies for SDM provision were tested; users and providers preferred physical CycleBeads to a paper version
- A cost-effective distance learning module was developed and tested
- The Knowledge Improvement Tool (KIT) was found to be an effective supervision tool
- SDM was included in the training curricula of MOH nursing programs

SCALE-UP PHASE 2007-2012

HOW SUCCESSFUL WAS SCALE-UP OF SDM IN GUATEMALA?

As of December 2012:

SERVICE EXPANSION

SDM services are available in 305 service delivery points in the three scale-up departments

Fourteen organizations have the capacity to train, deliver services or lend technical assistance on SDM

INSTITUTIONALIZATION

SDM has been integrated into the following components of the national FP program and sub-systems:

- Norms, policies, guidelines
- Pre-service and in-service training curricula
- Logistics systems
- MIS reporting systems

SDM USERS & KNOWLEDGE OF SDM OPTION

35.2% of women in the scale-up departments had heard of SDM at endline.

SDM users comprised about 2.3% of all FP users at endline.

Primary reasons former users stopped using SDM included becoming pregnant or wanting to become pregnant.

IRH officially launched SDM scale-up in late 2007. More than 60 stakeholders from the public, private and donor sectors joined IRH to develop, over the course of several meetings, a Guatemala-specific scale-up strategy. The ExpandNet framework was introduced as a guide for both setting and implementing the strategy. The goal of the five year project was to demonstrate whether SDM could be offered at scale in three departments. Combined with advocacy efforts, the evidence generated by this initiative could serve to guide decision-makers regarding the role of SDM in FP services, and that efforts to expand access to SDM at the national level would benefit the Guatemalan population and broaden options within the FP program.

Following the ExpandNet framework, the Resource Team, under the direction of IRH and the MOH's National Reproductive Health Program (PNSR), was formed to ensure the integration of SDM in the work of resource and user organizations. Key elements of the strategy used in Guatemala focused on:

a) Working in collaboration with public and private organizations that provide FP services, and
b) Building capacity to establish a cadre of trainers, from nurses to community volunteers, to be able to offer SDM
c) Ensuring SDM is tracked properly in reporting systems.

Scale-up focused geographically on Quetzaltenango, Sololá, and Santa Rosa, and efforts were made to ensure community-based (non-clinical) provision and a robust IEC component.

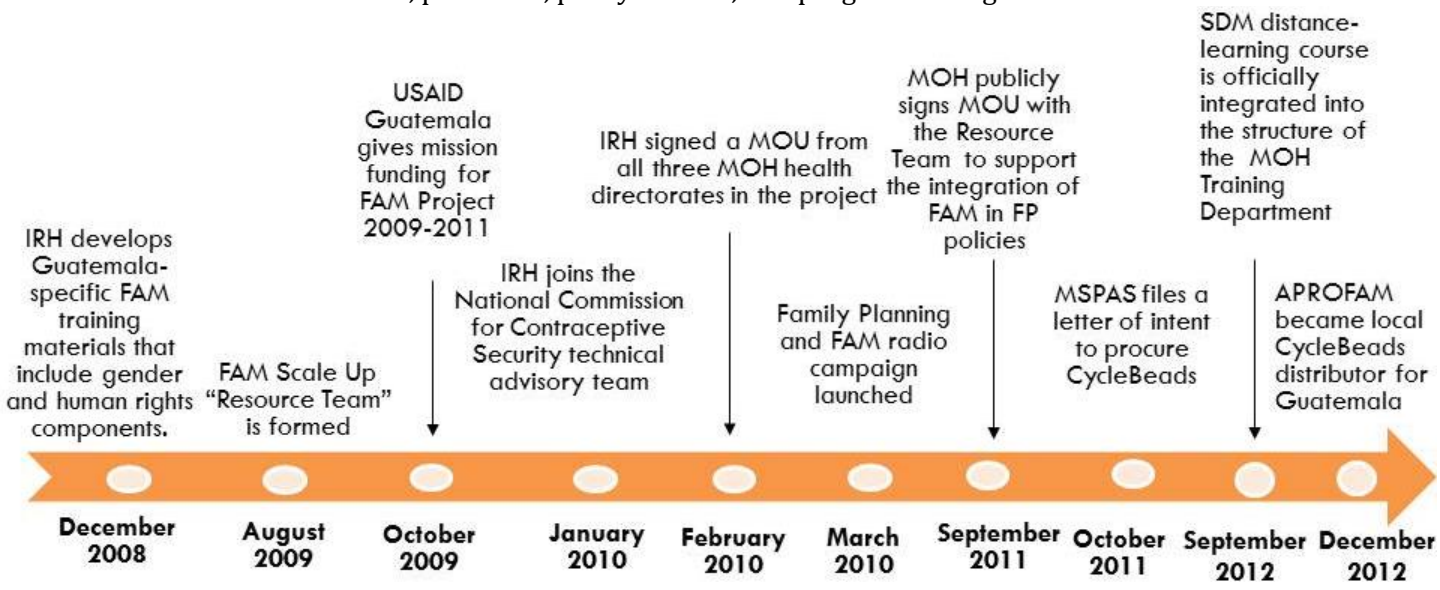
IRH staff in Guatemala included a Country Representative and one expert each in: IEC/Communications; Training; Research/M&E; and Finance/ Administration to facilitate the scale-up of SDM.

USING DATA TO GUIDE SCALE-UP

In Guatemala, IRH collected both primary and secondary information to guide SDM scale-up and assess progress. A *baseline* in 2010 consisted of an assessment of service delivery points, interviews with providers including CHWs, and a household survey with women and men. This multi-part assessment was repeated at *endline* in 2012 (see discussion of results below).

IRH also conducted *stakeholder interviews* in 2009 and 2011 to collect and analyze a range of views on FP and SDM in Guatemala's political and social environment, on scale-up progress, and on remaining tasks to ensure that SDM is sustained within the national FP framework. Stakeholders included representatives of communities and of organizations that provided FP services, established national guidelines, safeguarded women's rights, and/or funded FP and other health programs in Guatemala.

IRH maintained a graphic *events timeline* (see a condensed version below), which highlighted both project and political events and achievements from 2002 through 2012. The *Most Significant Change* M&E methodology was used by partner organizations in 2011-2012 to gain new perspectives on the scale-up experience from points of view that included those of users, providers, policy makers, and program managers.



AWARENESS AND USE: The endline assessment showed change since baseline in women's and men's awareness and use of SDM and other FP methods, and in SDM availability and service quality. IRH found that women had a greater *overall* awareness of FP methods at endline, as well as significantly greater specific awareness of SDM. However, though awareness of SDM had increased, it was still lower than awareness of other FP options. The endline reported change in awareness of only a few of the 16 FP methods included in the survey tool. At both baseline and endline, 54% of women thought SDM was a difficult method to understand. However, 50% thought it was an effective method, compared to 41% at baseline, and 77% believed it is economical, compared to 67% at baseline. Significantly fewer women at endline than at baseline thought it had side effects or caused health problems.

At baseline, only one survey respondent was using SDM, but at endline 2.3% of women practicing FP reported current use. The proportion is small, but represents an important gain in the two years between assessments, especially given the fact that only 35% of women had ever heard of the method. Overall, 72% of female respondents at endline claimed current use of a method. Most common among women using a FP method were injectable and female sterilization (41.1% and 35.3%); at 2.3 %, SDM was similar to IUD and implant (at 2.9% each) but lagged behind pill and condoms (6.1% and 5.2% respectively). Important percentages of women still report use of rhythm (9.3%) and withdrawal (8.2%), suggesting that SDM services are still not reaching many who need them.

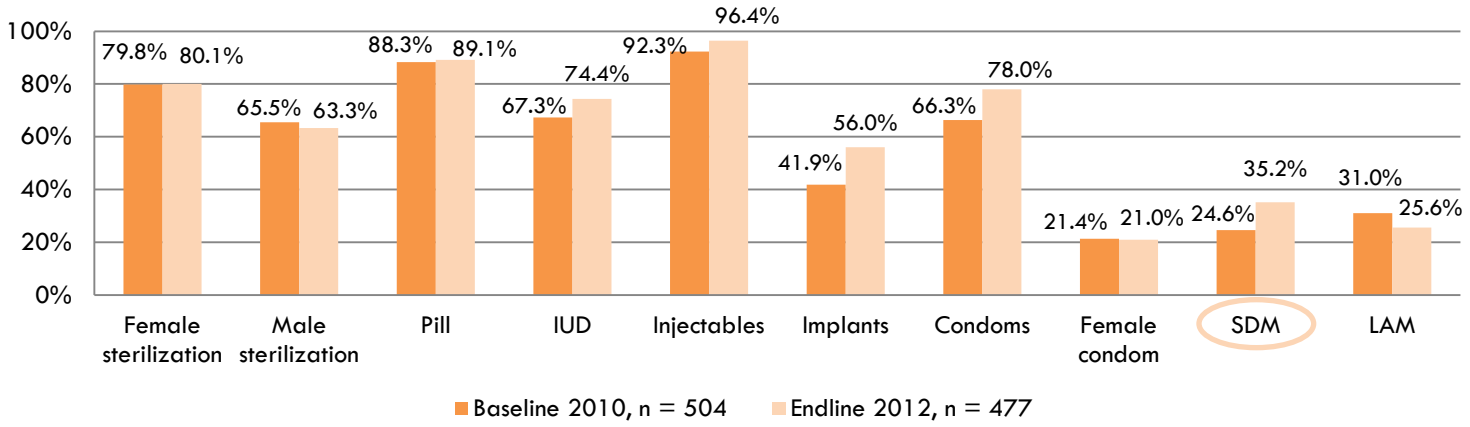
IN GUATEMALA, IRH & THE FP RESOURCE TEAM DEFINED THE SDM INNOVATION PACKAGE AS:

A modern, natural FP method available in all services that:

- attracts potential new users,
- facilitates understanding of how contraceptives work by providing a basic knowledge of the menstrual cycle,
- helps overturn myths and misperceptions about FP,
- helps women make decisions to take control of their bodies, and
- facilitates positive male involvement.

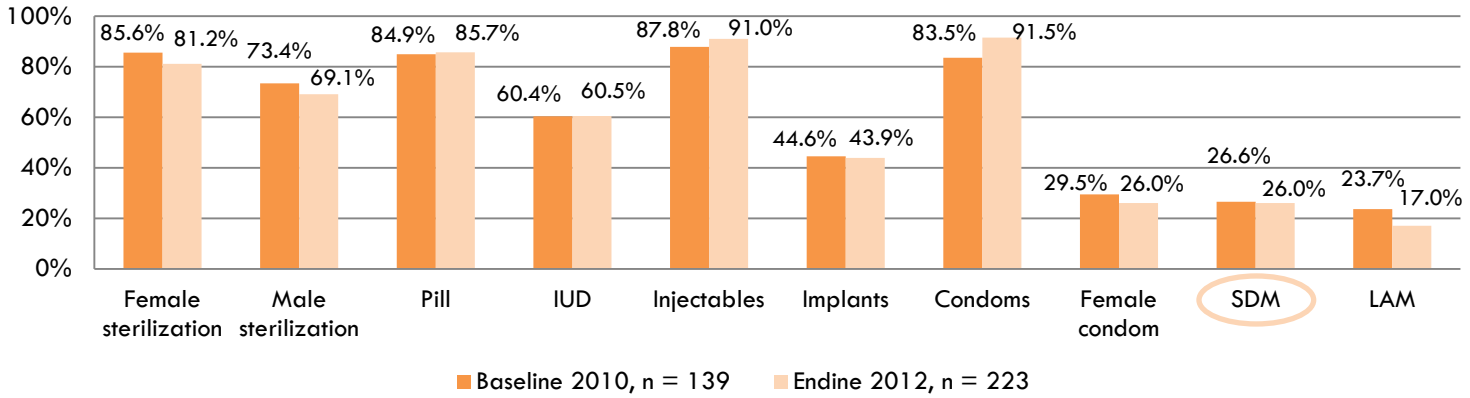
PERCENTAGE OF WOMEN WHO KNEW OF FAMILY PLANNING METHODS

IRH Household Surveys



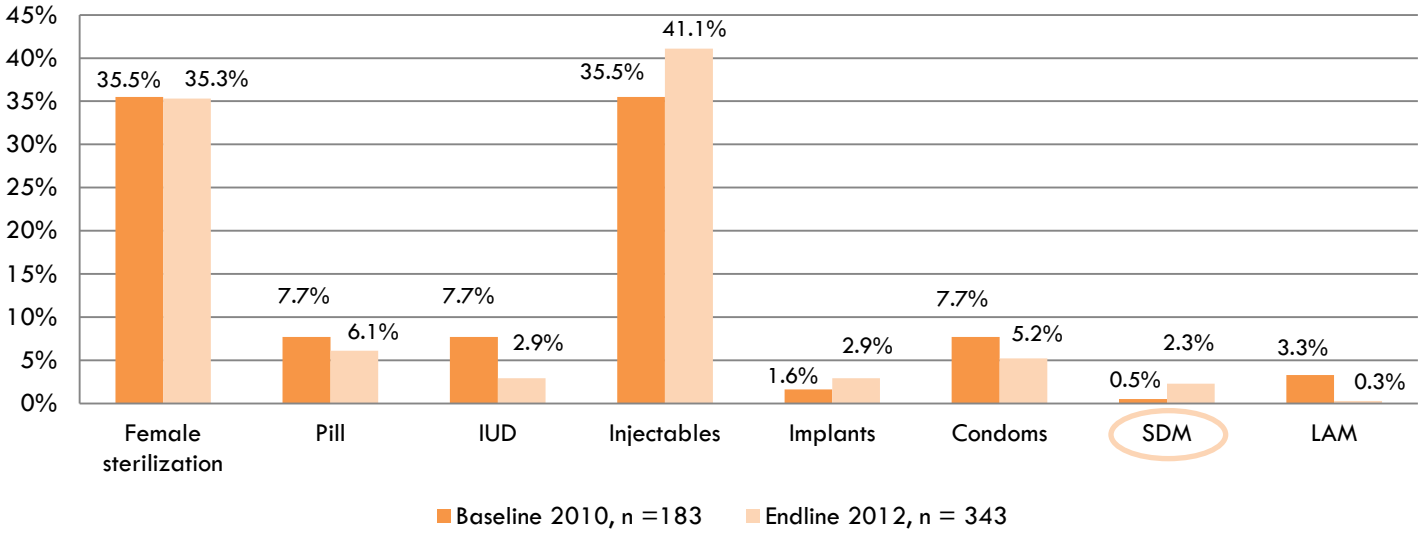
PERCENTAGE OF MEN WHO KNEW OF FAMILY PLANNING METHODS

IRH Household Surveys



METHOD USE AMONG WOMEN CURRENTLY PRACTICING FAMILY PLANNING

IRH Household Surveys

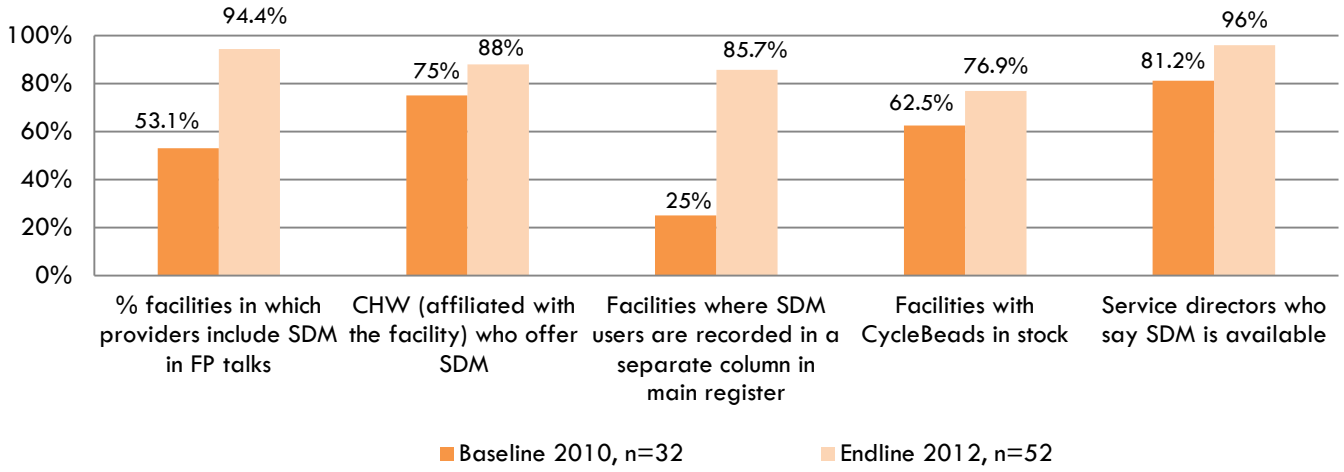


Male sterilization, female condoms, and traditional methods use were each less than 1.1% at both baseline and endline. Rhythm and withdrawal not shown.

AVAILABILITY AND PROVIDER PERFORMANCE: The endline found that SDM availability had increased in all areas surveyed, as had all direct measures of service provision. The chart below shows selected endline results on service provision.

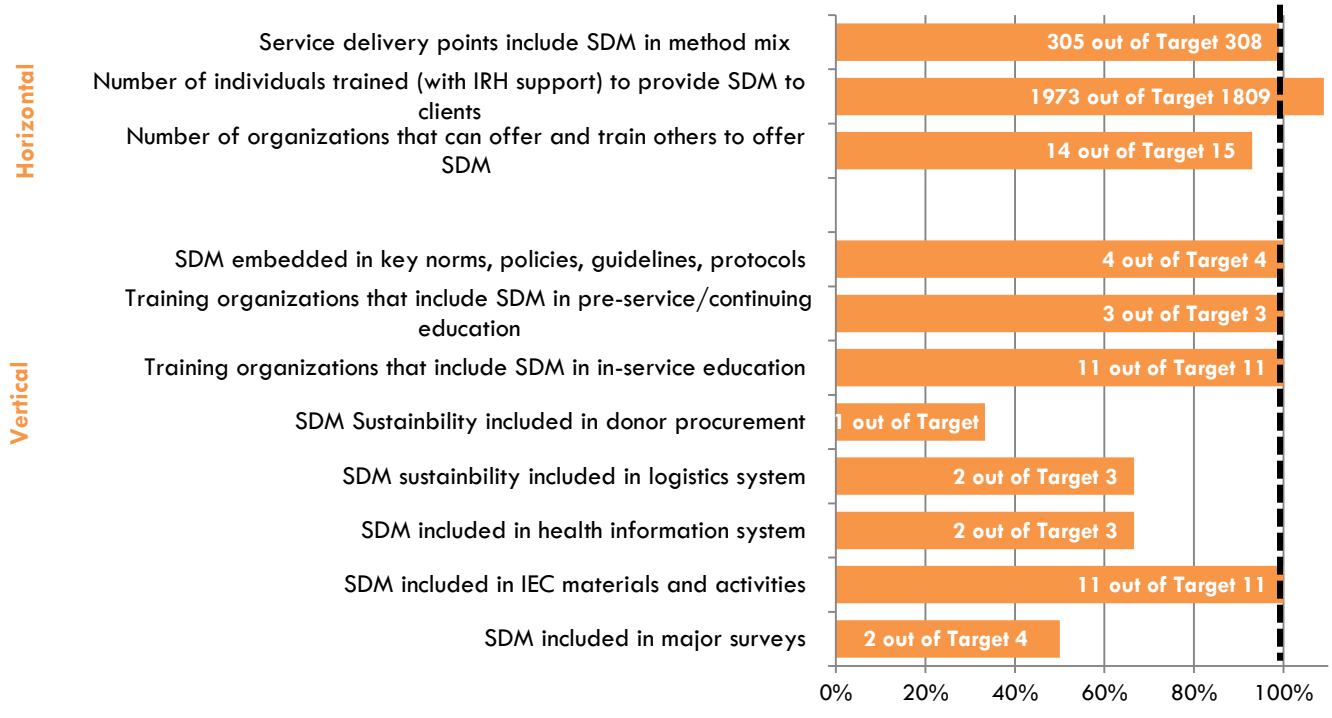
SELECTED SERVICE PROVISION RESULTS

IRH Facility Surveys



ACHIEVEMENT OF SDM BENCHMARK TARGETS

PROPORTION OF BENCHMARKS ACHIEVED, GUATEMALA



In Guatemala, as in all other countries where SDM was scaled up, the Resource Team developed a set of benchmark indicators, and made regular use of data from public and private service providers and from other sources to track progress against targets. The graphic above shows overall achievement of those targets in Guatemala.

The ExpandNet framework includes elements of both horizontal and vertical expansion. Work along the *horizontal scale* increased availability of and provider capacity to offer SDM in the three departments where scale-up was focused. By the end of 2012, 305 service delivery points included SDM in their method mix (99% of target), and nearly 2,000 individuals (109% of target) were trained to counsel clients in SDM. Fourteen organizations had the capacity to train others to offer SDM.

According to MOH and APROFAM facility statistics, 3,175 women accepted SDM over the course of the scale-up phase.

Activities on the *vertical scale* aimed for SDM's sustainable institutionalization in Guatemala's FP method mix and service standards. SDM was included in the MOH's national RH norms and its FP guidelines, in IGSS' FP norms, and in APROFAM's clinical protocol—the four standard documents that IRH identified as essential at the start of the scale-up phase. Having included SDM in these documents, the organizations could then include SDM in their training, IEC and service delivery activities, and in their information systems. SDM was also included in all of the pre- and/or in-service training programs targeted by IRH.

SDM's sustainable inclusion in donor procurement and logistics systems proved difficult. The MOH requested procurement of CycleBeads in 2011, but UNFPA (which is responsible for contraceptive purchasing for the country) denied the request, stating that 'CycleBeads are not included in the essential medicines list issued by WHO.' In 2013, UNFPA finally established an agreement with Cycle Technologies, the manufacturer and distributer of CycleBeads, to procure the commodity for countries that earmark their own funds for purchases through the AccessRH mechanism. However, after a second request was made by the MOH, UNFPA/Guatemala still declined to procure CycleBeads stating that the quantity requested (5,000) was too low in spite of the fact that their agreement with the manufacturer detailed a minimum purchase amount of 500. IRH therefore developed an agreement with APROFAM to enable the latter to serve as distributor of CycleBeads in Guatemala, creating a revolving fund from the sale of commodities to purchase additional commodities. The MOH could then buy CycleBeads from APROFAM in country. IRH also encountered difficulties embedding SDM in major surveys as planned. The method will be included in the next DHS in Guatemala, one of four surveys targeted by IRH.

Finally, IRH was able to determine, using MOH and APROFAM facility records and service statistics, that 3,175 women in the selected geographic settings accepted SDM over the course of the scale-up phase.

SCALE-UP AND THE GUATEMALA ENVIRONMENT

As a whole, the environment in Guatemala during scale-up was stable and even somewhat favorable to SDM and FP programs. The MOH's PNSR was IRH's main scale-up partner, followed by IGSS and APROFAM. IRH also worked closely with national networks of FP and SRH organizations. The state approved regulations in 2009 to operationalize its *Law on Universal and Equal Access to FP Services,* including establishment of a tax on alcohol sales to fund SRH programs. This was a significant step on a long road, and it was a key factor in the MOH's choice to integrate SDM into its contraceptive procurement plans. Elsewhere on the political front, leadership positions in the MOH and APROFAM changed several times during the scale-up phase; IRH devoted additional time and resources as needed to advocate with new leaders. The IGSS' FP service delivery was suspended during much of the scale- up phase, though it intends to resume shortly.

IRH's stakeholder interviews confirmed the general view that the MOH must be the national leader in FP, including their leadership in SDM integration after 2012 when the scale-up phase ended. The MOH accepted this role and

confirmed its responsibility to promote all methods equally, without bias. IRH ensured that MOH, and especially PNSR, representatives participated in key planning and research activities. An overall lack of resources in the MOH budget, including in its FP program, suggests that future SDM integration and scale-up may be challenging.

Political and religious environments are closely linked in Guatemala. As noted, the Catholic Church opposed the *Law on Universal and Equal Access to FP Services*. IRH made explicit efforts to advocate for SDM's acceptance by various church actors. A Catholic university and two FBOs (CRS and Caritas) were interested in integrating SDM in their curricula or services, they were unable to gain permission from the church.

USAID in Guatemala provided direct funding to IRH for the first two years of scale-up, then allocated its FP support budget to several new, bilateral health programs. IRH continued activities with funds from USAID's central grant to IRH in Washington, D.C., and following USAID's request, attempted to collaborate with its large-scale, bilateral health programs. However, some of the implementing agencies showed little interest. Meanwhile, UNFPA did not respond to either of the MOH's explicit wishes to procure CycleBeads, in spite of UNFPA headquarters' decision to add them to its commodity catalog.

RESOURCE AND USER ORGANIZATIONS

The strategy-setting workshops for the scale-up phase resulted, among other things, in the formation of a Resource Team whose membership included several representatives of the MOH (PNSR and other divisions), IGSS, APROFAM, several NGOs, and networks of organizations that provided services, raised awareness and safeguarded rights. These institutions identified a potential to incorporate SDM into their activities, and worked on SDM integration and advocacy through their organizations and networks. Over time, their work centered on the emerging theme of 'community-based FP services' in a country where FP had been focused solely on facility-based health services. The Resource Team grew to consider itself an inter-institutional board with operational interventions, designed to bring FP to the community in a systematic manner, in part by identifying local Resource Teams (one in each focus department) that both implemented and collaborated with the central FP Resource Team.

Women's empowerment, male involvement, and couple communication are intrinsic characteristics of SDM and were emphasized throughout the scale-up process. Through integration of the SDM in its FP program, the MOH was able to accomplish its goal of incorporating cross-cutting issues such as sexual and reproductive rights, gender and sexuality.

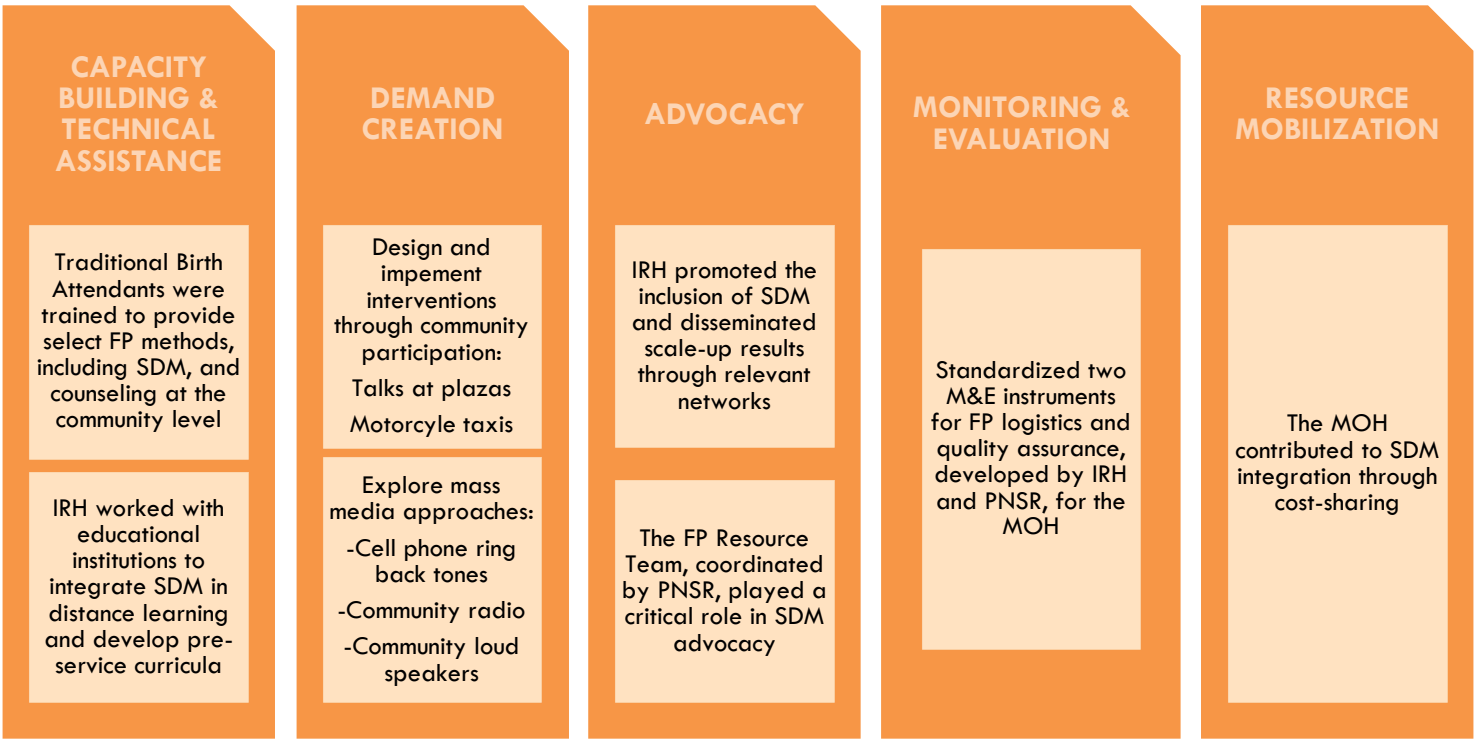
The MOH and APROFAM have the greatest capacity to sustain SDM services in the future.

As the official scale-up phase drew to a close in late 2012, IRH and the MOH drew up plans to transition key activities (in advocacy, capacity-building, IEC, logistics and procurement) to members of the Resource Team.

User organizations in Guatemala included an array of NGOs that were members of the MOH-organized network of extension workers. More than a dozen such organizations received training and technical assistance to offer SDM to clients. However, unlike major service delivery organizations (and members of the Resource Team) MOH, IGSS and APROFAM, these NGOs were more likely to suffer serious capacity deficits when there was staff turnover. And, because they received CycleBeads directly from IRH, their future supply pipeline was less certain.

In sum, MOH and APROFAM have both the greatest capacity and likelihood to sustain SDM services in the future. Of note, the MOH is mandated to do so, but APROFAM is likely to base its provision of SDM services on demand for CycleBeads because it is a private, self-sufficient organization which relies on revenue generation for its success.
In IRH's analysis, several incentives may favor ongoing integration or sustainability of SDM in the FP method mix. First, the MOH embedded the method in several key protocols which mandated that the method be offered. Guatemala also hosts several watchdog organizations that monitor the availability and quality of health services, including a range of FP methods, as stipulated by law.

STRATEGIC CHOICE AREAS



CAPACITY BUILDING AND TECHNICAL ASSISTANCE:

In addition to including SDM in general FP training, using a training-of-trainers approach, and applying the supervision checklist (KIT) as both an assessment tool and an opportunity to detect and fill gaps in provider capacity, IRH notes several other ways it contributed to capacity building in Guatemala.

Strategy for Training Traditional Birth Attendants. A large proportion of rural, indigenous Guatemalans do not live near even a third-tier health post, and have no access to clinic-based FP services. Using standards set forth in MOH's own national FP Guidelines, IRH provided technical assistance to PNSR in the design, implementation and evaluation of a strategy that authorized traditional birth attendants (TBAs) to provide selected contraceptives and counseling at the community level. This initiative was implemented on a small scale in Quetzaltenango (53 TBAs and 15 facilitators) and Santa Rosa (32 TBAs, seven facilitators). To evaluate

effectiveness of the training, IRH used the KIT and found that 76% of traditional birth attendants could provide correct initial counseling for the pill, as could 54% for SDM. Using service statistics for a period of nine months prior to the intervention and the nine-month period of the intervention, a moderate increase in FP users during the intervention period was seen.

Engaging Educational Institutions. In 2010, IRH undertook a survey of seven educational institutions for health care providers, to determine the quality and effectiveness of pre-service FP training, including SDM. These schools for auxiliary nurses and rural health technicians had incorporated FP and SDM training, and IRH found that auxiliary nurses' training positioned them to best provide FP in both the community and the health service setting. IRH then worked to include SDM in nurses' pre-service training at 10 additional nursing schools in Guatemala. IRH also developed a distance-learning module on SDM, in two formats: self-study and online. The MOH's training department reported certifying more than 200 providers of various types via these modules. The online course forms part of the MOH platform, while the self-study course has been offered in departments outside of the three FAM focus departments through the MOH's Training Department.

IRH developed an SDM distance learning module that is available both as a self-study course and online.

ADVOCACY: IRH participated in relevant meetings and networks to promote inclusion of SDM and to disseminate the results of scale-up and research. IRH generated opportunities for partners and engaged them in the scale-up process, which encouraged partners to become more involved in and eventually take ownership of some components of scale-up. The FP Resource Team, coordinated by PNSR, played a critical role in advocacy. The Resource Team successfully advocated to include CycleBeads on MOH procurement lists and to enable TBAs to offer condoms, pills, CycleBeads and LAM at community level for the first time in Guatemala. PNSR advocated to make the Resource Team's existence official within the MOH system, and contributed resources for the interventions and monitoring activities that the team undertook. PNSR also ensured financing for the MOH to purchase CycleBeads supplies through the government open contract system.

DEMAND CREATION: An IRH assessment found that health providers in charge of promotion had little specific training or materials with which to do their jobs, and missed many opportunities to reach men and women with information. IRH designed a guide for training health promoters which included theoretical and practical portions. Training focused on ways of bringing FP and SDM information to the population. IRH worked with local NGOs on community and mass media FP awareness raising activities.

MONITORING & EVALUATION: The MOH had several health data collection tools, but none was specific to FP. Moreover, user organizations tended to have weak M&E systems. PNSR identified the need for standardized M&E instruments for FP programs; prototypes of a logistics and a quality assurance tool were developed by PNSR and reviewed by the Resource Team. The instruments are considered official tools and will soon be disseminated through the MOH for implementation.

RESOURCE MOBILIZATION: Since the SDM introductory phase, the MOH, along with other partners, contributed financial resources for SDM integration by way of cost-sharing. However, continued resource mobilization for SDM integration and scale-up will be difficult due to an overall lack of resources in national budgets, including the RH program.

KEY ELEMENTS THAT FACILITATED SCALE-UP IN GUATEMALA

1	2	3	4
Partners were involved in all phases of scale up, from defining the innovation and desiging the scale up strategy to advocating for SDM integration.	Capacity building activities and systematic M&E activities with the MOH stregthened the system as a whole.	Commitment of Guatemalan government to reaching indigenous populations through innovative approaches.	The Law on Universal Access to FP Services encouraged the Resource Team to advocate for SDM inclusion in FP services.

The scale-up efforts carried out by IRH and its partners carried out in Guatemala were substantial, and endline results and benchmarks show important achievements. IRH notes several factors in the operating context that supported both activities and successes.

1. Partners, and especially PNSR, were involved in defining the innovation and designing the scale-up strategy. The buy-in generated in these earliest days was valuable throughout the scale-up phase. Not only did partners join in the advocacy for SDM integration (into new materials, guidelines, capacity-building activities, etc.), they took shared responsibility for the outcome. These results were achieved by an Inter-institutional Resource Team over the course of more than three years.
2. A weak public-sector M&E system meant that IRH had to lead efforts to monitor the progress and quality of SDM integration. But joint activities, such as M&E visits and capacity-building activities, allowed the MOH to identify gaps and take strides to improve the system. One of the lessons learned was the critical and complementary role the M&E process can play in systems strengthening. Working to identify and address existing gaps improves both an individual program's success as well as the system as a whole.
3. The government of Guatemala managed several programs designed to reduce the marginalization of indigenous populations, and this commitment ultimately supported IRH and partner advocacy to expand access to FP and SDM. IRH's intervention, in which traditional birth attendants were trained to distribute certain methods in the community, was an opportunity to bring FP services out of the clinic and into the community. Results from this pilot study were largely positive; however, the intervention would need to be expanded to make a measurable impact.
4. The *Law on Universal Access to FP Services* created a dialogue in Guatemala about the importance of informed choice, and energized women's organizations, including several on the Resource Team, to demand inclusion of all methods, including SDM, in FP services.

SUSTAINABILITY OF SDM IN GUATEMALA

Significant progress has been made across the various components of scaling up SDM at the national level. To assure that these achievements are sustained and/or advanced upon the end of the FAM project, however, there is a need to identify key actors and strategies that will move SDM forward in terms of advocacy, capacity building, logistics and procurement, IEC, and HMIS and M&E.

SCALE-UP COMPONENT	ACTION FOR SUSTAINABILITY	RESPONSIBLE PARTY
ADVOCACY	• Advocate for inclusion of FAM as new materials are developed and guidelines, protocols and surveys are updated. • Incorporate the SDM Integration Toolkit under the MOH website.	Resource Team MOH National SRH Program
CAPACITY BUILDING	• Maintain resources and provide technical assistance to expand SDM capacity building activities nationally. • Maintain SDM online course on MOH website.	Resource Team organizations MOH Training Department
LOGISTICS AND PROCUREMENT	• Support CycleBeads distribution in the public and private sectors. • Distribute procurement information via AccessRH.	APROFAM MOH, UNFPA
IEC	• Use and incorporate SDM IEC resources (e.g. radio programs, invitation cards etc.) into project activities.	USAID bilateral members MOH National SRH Program
HMIS/ MONITORING & EVALUATION	• Institutionalize FP M&E supplemental instrument developed by the Resource Team, with support from IRH. • Provide financial assistance for M&E visits to public/private health posts. • Conduct M&E visits to public and private sector health post. • Include SDM in 2014 DHS.	MOH National SRH Program Resource Team USAID bilateral members USAID/Guatemala Mission