Scaling Up the Standard Days Method® of Family Planning in Five Countries

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Acknowledgements

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List of Abbreviations

ABEF/ND	Association pour le Bien-Etre Familial/Naissances Désirables (IPPF Affiliate)
DRC	Democratic Republic of Congo
FBO	Faith-Based Organization(s)
FAM	Fertility Awareness-Based Methods
HMIS	Health Management Information System(s)
HLL	Hindustan Lifecare Limited
IEC	Information Education and Communication
IRH	Institute for Reproductive Health at Georgetown University
KIT	Knowledge Improvement Tool
MDG	Millennium Development Goal(s)
MOH	Ministry of Health
NGO	Nongovernmental Organization(s)
PSI	Population Services International
SDM	Standard Days Method®
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Abstract

Background

This paper uses the ExpandNet framework to analyze the process of scaling up access to an innovative, natural, modern family planning method, the Standard Days Method® (SDM), in five countries: the Democratic Republic of the Congo (DRC), Guatemala, India, Mali and Rwanda.

Methods

Findings are assessed at the midpoint of a six-year scale-up project and are based on in-depth interviews about project implementation with headquarters and field staff of the Institute for Reproductive Health of Georgetown University, participant observation through field trips to two countries, and review of country-level monitoring data and project documents.

Results

SDM was substantially institutionalized in policies, norms and guidelines and was made available in numerous service delivery sites over the three-year period, although the extent of expansion varied significantly. Demand creation efforts were more limited. Results on the process of expansion showed that scaling up of SDM required 1) a considerable degree of change in the behavior of method users and in the service delivery system; 2) substantial simplification of the training process and materials; 3) adaptation of promotional strategies related to male involvement, condom use, gender issues and other socio-cultural characteristics of the country; 4) capacity building of the public sector in the provision of family planning, beyond a narrow focus on SDM; and 5) partnering with NGOs and the private sector. Government interest in the method in the five countries was an important factor in explaining the success attained; however, continued professional bias among health providers and decision makers remained a significant obstacle. The dedication and the level of effort of the IRH resource team supporting activities and their close coordination with the government were important factors in explaining the progress made.

Conclusion

The country studies identified three major conclusions that have implications for future scaling up of family planning and other health interventions. These relate to: 1) the importance of systems-based strategies rather than single-focused approaches such as training, 2) the need to strike a balance between working to increase the supply-side vs. strengthening the demand-side, and 3) the central role of the resource team working to expand and institutionalize the innovation.

Background

As countries seek to achieve the Millennium Development Goals (MDG), many efforts to scale up effective health innovations are underway. There is also increasing attention on the development of systematic approaches to guide the process of scaling up and provide lessons about what determines success or failure (*1-3*). This paper presents findings from efforts to expand use of the Standard Days Method® (SDM) of family planning in five countries, guided by a systematic framework developed by ExpandNet (*1*).[i] While illustrating the successes of these efforts (Tables 1 and 2), this paper focuses on key lessons learned about the *process* of large-scale introduction of SDM. For example, the innovation introduced in each country was the same, but the strategies for successful expansion have varied according to the country context (*4*).

Methods

The analysis presented in this paper is based on data that were assessed at the midpoint of a six-year scale-up project, a benchmark that permits analysis of the relative success of different approaches utilized in the five countries. The data were collected through a variety of qualitative techniques. These included 1) in-depth interviews with IRH headquarters staff and the Country Representatives about project implementation, 2) review of project reports and other documents, and 3) participant observation by the authors through field trips to Guatemala and Mali. During these field visits the authors, accompanied by local IRH field staff, held informal conversations with policymakers, program managers, providers, local community leaders, village volunteer FP workers and other community women and men about family planning in general and about SDM and the implementation of project activities more specifically. Furthermore, during the first three years of the project the authors participated in the annual 3-4 day IRH international staff meetings where the country representatives met together with headquarters staff to discuss the progress of the project and compared obstacles encountered, potential solutions and lessons being learned about scaling up. In addition, the quantitative data concerning project implementation presented in Tables 1 and 2 are derived from country monitoring reports of the FAM Project. Throughout the writing of the paper the authors held a number of discussions with IRH staff to validate analysis of the data. Finally, several IRH headquarters and field staff provided reviews of the paper to correct any inaccuracies.

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[i] ExpandNet is an informal network of public health professionals from around the world which seeks to advance the practice and science of scaling up. The authors provided IRH guidance on scaling up SDM in the five countries (*1*).

The Standard Days Method® and the FAM Project

SDM is a component of the Fertility Awareness-Based Methods (FAM) Project of the Institute for Reproductive Health at Georgetown University (IRH) in Washington DC. This USAID-funded project (2007-2013) seeks to increase worldwide access to effective natural methods within the context of ensuring informed choice for women and their partners.

FAM builds on earlier projects in which IRH developed, tested and introduced SDM and other fertility awareness-based methods of family planning in over 20 countries. Appropriate for women whose menstrual cycles are between 26 and 32 days long, the

Women in Mali demonstrating CycleBeads® [Photo Credit: Ruth Simmons]

method identifies days 8 through 19 as the likely fertile days. To prevent pregnancy, the couple avoids unprotected sex on these days by abstaining or using a condom. A woman can use CycleBeads®, a color-coded string of beads, to help track the days of her menstrual cycle and identify the fertile days. Previous studies show that this method is effective, low cost and useful for both giving women a new contraceptive option and for expanding overall contraceptive prevalence. It appeals primarily to women and couples who are new to family planning or who are concerned about side effects of other modern methods (*5-7*).

The FAM Project is working with a wide range of partners to scale up availability of SDM in five focus countries: Democratic Republic of the Congo (DRC), Guatemala, India (in Jharkhand state), Mali and Rwanda. The project's role is to create a supportive policy environment, build capacity to offer FAM services and to develop the tools to help ensure quality services. IRH staff at headquarters and teams in each focus country provide technical assistance to in-country partners who wish to introduce the method, including ministries of health (MOH), nongovernmental organizations (NGO) and faith-based organizations (FBO). They also work closely with technical partners at the global and country levels to implement the project.

The ExpandNet framework for scaling up

As IRH moved from development and testing of SDM to large-scale expansion they decided to apply the ExpandNet framework, tools and experience to help guide their thinking about strategies for scaling up (*1*). The ExpandNet framework is based on a review of literature from the fields of family planning, health and development; the diffusion of innovations and research utilization; and the management and policy sciences. It also builds on experience of ExpandNet members working on scaling-up initiatives in Asia, Africa and Latin America. ExpandNet defines scaling up as "*deliberate efforts to increase the impact of health 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.*" (*1*)

Figure 1[i] provides an overview of the framework, representing the elements of the systematic approach to planning and managing the process of scaling up. The centerpiece is the scaling-up strategy, the means by which successful innovations are communicated, transferred, or otherwise promoted and managed. An effective strategy must be congruent with the elements which surround it – the innovation, the user organization which is expected to implement the innovation on a large scale, the resource team which supports the process and the larger social, economic and institutional environment – so as to maximize the potential for success. At the same time strategic choices must be made related to the types of scaling up, dissemination and advocacy, the organizational processes to be used, costs and resource mobilization, and monitoring and evaluation. The two most important types of scaling up are institutionalization and expansion.[ii] Institutionalization refers to ways of anchoring the innovation in policies, regulations, norms, budgets, logistics and management information systems. Expansion means scaling up to new geographic sites or serving larger or different population groups.[iii]

Figure 1. The ExpandNet framework for scaling up

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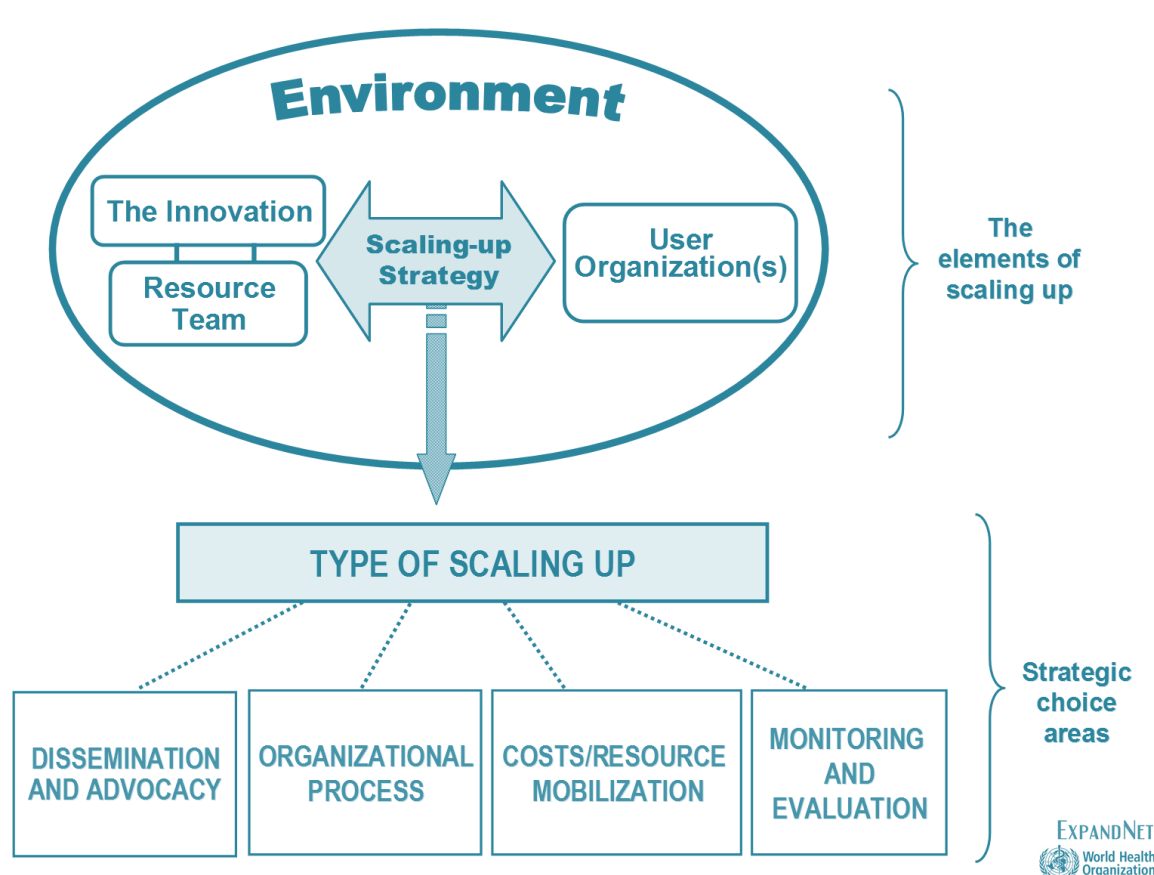
[i] Source: "Nine steps for developing a scaling-up strategy" (*19*).
[ii] Also referred to as vertical and horizontal scaling up respectively.
[iii] For a detailed description of the ExpandNet framework and tools see Simmons (*2*), ExpandNet/WHO (*1*), and [www.expandnet.net]).

Results and Discussion

The following analysis presents key lessons from the experience of introducing SDM in the five focus countries, organized according to the elements and critical choices identified in the ExpandNet framework:

1. The innovation: managing change and adaptation

The innovation refers to the interventions that are being scaled up. ExpandNet uses the concept of innovation because the practices that are being introduced are new in the local setting, although they may have been widely implemented elsewhere (*8*). In each of the five countries the innovation refers to the introduction of SDM and related necessary interventions such as training, supervision, recordkeeping and procurement. The degree of change implied by the innovation is a major determinant of its scalability; those requiring substantial change are more difficult to scale up than those that are relatively compatible with existing culture, norms, practices and resources (*1,9*).

SDM requires couple communication. [Photo Credit: IRH]

SDM's degree of change for women and couples: SDM is attractive to some women and couples because it is a natural method with no side effects and is largely compatible with local value systems. But it requires careful attention to a woman's cycle, partner support and either abstinence or condom use during the 12 fertile days. Research shows that learning to identify the fertile period with the use of CycleBeads is not difficult, if the method is clearly explained and supported (*10*). But for some couples managing the fertile period may involve too much change because abstinence or condom use require a higher degree of spousal communication than they are used to, as well as changes in sexual attitudes and behavior related to abstinence or condom use. For others, understanding the menstrual cycle leads to positive feelings about greater control over fertility and improved couple communication. Data suggest that successful SDM use requires: 1) effective screening so that only couples who want to use the method, and are eligible to do so, adopt it (*11*); 2) offering SDM as one of a range of contraceptive methods so that it is genuinely an informed choice (*7*); and 3) ensuring that male partners receive information about the method and support its use (*12*).

The degree of change required in the service delivery system: If an innovation fits in easily with the standard operating procedures of the organization in which it is to be implemented it will be more likely to succeed. On the other hand if it requires substantial change--new behaviors and/or values on the part of providers; additional human or financial resources; or structural rearrangements--it will be far more challenging (*1,13*).

From a user organization point of view there is more change required in introducing SDM than may appear at first sight. It is "easy" in that it does not require extensive training, equipment or facilities. It can be taught anywhere by health and community-based workers if they are properly trained and supervised. CycleBeads are durable and do not require regular re-supply although couples who use condoms during

the fertile period need reliable access to them. Moreover, some SDM users may benefit from ongoing support from the implementing organization. While most women learn how to use SDM in a single counseling session of about fifteen minutes, this may be a departure from prevailing patterns of information-giving for clinic-based providers who normally spend much less time explaining methods to new users. Especially in the public sector, doctors and nurses may not have the fifteen minutes required for SDM counseling and some providers lack the capacity or inclination to empower women to choose a method.

A response has been to shift the task of teaching women about SDM to community health workers. They interact with the local population more often than doctors and nurses and have more time to explain the method and provide follow-up. They are also less likely to have a bias towards clinical contraceptive methods and are more comfortable talking about user-controlled methods. In all five countries community health workers from the public or NGO sector have been involved in providing SDM. In Mali, for example, community women leaders were successfully trained to counsel potential clients on SDM and to distribute CycleBeads.

Simplifying the training process and materials: The literature on scaling up has shown that successfully tested innovations typically need to be simplified when they are scaled up (*13-16*). Pilot projects have the luxury of testing interventions that are more complex, costly and labor-intensive than they can afford to be when they are integrated into large-scale public health service programs. Thus, one of the first requirements is typically a process of paring down the innovation to its most essential components. This was confirmed in the case of SDM.

The need to simplify was particularly clear in regard to the length of training and training materials. During the pilot phase, IRH's training curriculum required two days, involved both didactic and practical sessions, and was directed at relatively high levels of providers. In contrast, during scaling up, IRH had to build training capacity within other organizations, including the MOH, educational institutions, professional associations and NGOs that normally have little time to devote to training for a single method. In the typical public sector family planning training program, no more than two hours could be devoted to SDM. Scaling up has been described as a process of moving "from exemplars sustained by extraordinary supports, to typical applications with typical support".[i] Having to reduce training from two days to two hours is a good illustration of that process.

In addition, the technical complexity also had to be simplified in order to enable lower-level providers to counsel local people. For example, in Mali and DRC, training materials eliminated excessively technical terms and in India, a comic book format was developed for community-based providers. Trainers who had participated in the pilot testing sometimes challenged such simplification; they were reluctant to acknowledge that much of the technical information provided earlier was unnecessary for effective training of local providers. Furthermore, the Information, Education and Communication (IEC) materials intended for SDM users needed to be simplified. For example, the DRC research showed that the information accompanying the CycleBeads was not well understood by the target population. After discussions with the MOH and the partner agency, Population Services International (PSI), the product

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[i] See Fixsen (*20*) as well.

insert was revised so it was understandable to semi-literate users and then translated into all four official languages. But the literature on scaling up cautions that extensively altered innovations might not produce the same results that were attained at the pilot stage: the central components of the innovation must remain intact. To address this issue, IRH developed the Knowledge Improvement Tool (KIT)[i] for use by provider organizations to monitor and evaluate provider competence in SDM provision a few months after receiving training. IRH has worked with organizations to apply the KIT after training. Ensuring that such tools will become a routine part of post-training implementation is important if the quality of implementation is to be sustained as scaling up proceeds.

Adapting the innovation to the local context: The importance of adapting innovations to different socio-cultural, economic and institutional settings is a central lesson of scaling up (*8*). The experience of introducing SDM in several countries reinforces this point. For example, the FAM Project found that the cultural acceptability of condom use during the fertile period varied: it facilitated method introduction and scale up in some countries but hindered it in others. In India, where condoms have been part of the family planning program for decades, condom use appeared to be more acceptable than in Mali where they are predominantly associated with prevention of sexually transmitted infections including HIV. In Mali, exposure to contraceptive services and especially condoms as a family planning method is recent. Therefore promotional strategies, especially emphasis on the role of male involvement and gender issues, needed to be adapted to these socio-cultural characteristics. Similarly, in some countries, SDM was acceptable as a straight-forward family planning method while in others, its contributions to gender equity and couple communication were attractive to decision-makers.

2. The user organizations: building implementation capacity

In the ExpandNet framework the user organization refers to the institution(s) or organization(s) that seeks to, or is expected to implement the innovation on a large scale. In all countries where SDM has been introduced, the MOH is the main user organization. In fact, IRH works only in countries where the national MOH has expressed interest in the introduction and scale up of SDM. However, the exact nature of the Ministry's role and how it partners with NGOs, the private sector or social marketing varies considerably.

In Jharkhand, India, the user organization includes only the Ministry of Health and Family Welfare. In the DRC by contrast, the public sector family planning program relies heavily on national and international partner organizations to provide contraceptive services, including Catholic Relief Services, Conduite de la Fécondité, CARE, and ABEF/ND. The MOH primarily provides overall coordination of their efforts. As a result the local IRH team has to interact with a much broader range of user organizations than the team in Jharkhand. The situation in Guatemala, Mali and Rwanda is similar to that of the DRC.

Helping to build capacity in the public sector: Because in most low-income countries the capacity of the public sector to provide equitable access to quality health services is constrained (*17*), those who wish to advance innovations must ensure that scaling up of specific innovations contributes to,

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[i] KIT is available on the IRH website [here](#).

rather than detracts from, building national health systems' capacity.[i] The strategies used in the large-scale implementation of SDM provide examples of how even small resource teams who support the user organization in scaling up can contribute to such capacity building.

In Jharkhand, the MOH and Family Welfare Department has been eager to have the local IRH team conduct contraceptive technology updates and training for public sector providers as part of SDM introduction. Given that capacity building of the family planning program is an important need in this new state, the local IRH team has taken on this responsibility to the extent feasible, even in districts where they are currently not yet working on SDM introduction. In addition, they focused on developing training skills in local personnel rather than bringing in highly-skilled training professionals from New Delhi, in a deliberate effort to build sustainable training capacity in Jharkhand.

In the DRC, the IRH team helped build the capacity of the national family planning program by assisting with field supervision of overall family planning services using the KIT supervisory tool, and by providing support to the development of a Health Management Information System (HMIS) for all methods of family planning. Through their initiative, regular coordinating meetings between the Department of Reproductive Health, USAID and partner organizations were established. Similarly, in Guatemala, the IRH team facilitated the process of bringing relevant agencies and departments together as a resource team for family planning under the umbrella of the MOH. This team meets

A traditional birth attendant in Guatemala who is in training to offer various family planning methods [Photo Credit: IRH]

regularly, and makes collective decisions to improve family planning services. For example, the resource team is advocating for policy change that will allow midwives to distribute certain contraceptive methods. This collaboration has facilitated coordination among a variety of departments related to family planning and has survived four changes in leadership of the MOH team.

Collaborating with NGO partners: In several countries where SDM is being introduced, NGO partners play an important role in the provision of family planning services. IRH has actively sought opportunities to collaborate with these partner organizations as a means of extending the reach of SDM. In the DRC public sector family planning programs are largely carried out by national and international NGO partners, including FBOs, and in Rwanda and Mali the government also relies on partner organizations to provide family planning services in certain parts of the country. Given that the capacity of NGO partners to provide services tends to be strong, IRH has focused on training the trainers in these institutions on SDM and subsequently relies on them to train providers. Once SDM has become an integral part of an NGO's service system, its further expansion to new areas typically takes place without IRH's involvement.

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[i] See ExpandNet and WHO: "Priorities for supporting successful scaling up of health innovations: Summary recommendations of a meeting", The University of Michigan School of Public Health, Ann Arbor, May 6-7, 2009 at [http://expandnet.net/PDFs/ExpandNet-WHO%20Scaling%20Up%20Meeting%20Priorities%20FINAL.pdf].

However, there are also challenges in working with NGO partners. Given that many NGOs are dependent on donor support, SDM service delivery and expansion can be disrupted when funding is irregular or discontinued. In some cases, partners had other priorities and attention to SDM provision was not consistently sustained. In addition, some FBOs reject condoms and do not offer their constituencies this option for managing the fertile period.

The role of the social marketing and private sectors: Social marketing and private sector outlets, especially pharmacies, provide an important additional channel for scaling up the distribution and use of SDM. For example, in Mali, PSI is developing private-sector capacity to promote and sell CycleBeads. Given their mass media campaigns and ability to engage a large number of private sector outlets, PSI can significantly expand access to SDM. However, there are also limits to what can be achieved through the private sector. Being primarily motivated by profit margins and evaluated on how many contraceptive commodities are sold, retail outlets may be less likely to provide essential SDM counseling. Thus IRH is exploring ways in which the necessary knowledge for using the method appropriately can be effectively conveyed through the informational inserts provided with CycleBeads.

3. The environment: taking advantage of opportunities and dealing with constraints

The environment in the ExpandNet framework refers to the conditions and institutions which are external to the user organizations and resource team, but fundamentally affect the prospects for large-scale expansion. While some environmental factors remain relatively stable over time, others—in particular, policy and political contexts—often undergo rapid change. Policy windows may open but they can also close quickly. The extent to which those who seek to scale up an innovation can benefit from windows of opportunity and avoid constraints is a major determinant of success (*9*). Comparison of the different environmental contexts of the five SDM focus countries reveals both differences and similarities in the opportunities and challenges encountered.

Benefiting from government commitment to family planning and the demand for SDM: A major factor in the policy environment is the government's commitment to family planning and provision of a range of contraceptive choices; if such commitment is strong, the introduction and scale up

A woman shares SDM in a DRC community. [Photo Credit: IRH]

of SDM will benefit. This was clearly the case in the DRC where after the end of the devastating war period, the government identified family planning as an intervention that would contribute towards reconstruction. The same was true for Rwanda. By contrast, the relatively low commitment to family planning in India at the beginning of the 21st century, together with the program's emphasis on long-term and permanent methods, has been a definite constraint.

An equally important factor in the larger environment is the demand for expanded contraceptive options,

especially those that can reach women and couples with poor access to services. Focus countries for the FAM Project were selected based on whether demand for SDM would be likely, as measured by unmet need for family planning and interest in alternatives to available methods, particularly methods which actively engage men or have no unwanted physical side effects.

Working within bureaucratic and political constraints and taking advantage of windows of opportunity: Because scaling up of SDM takes place under the auspices of public sector programs, its progress was strongly affected by bureaucratic and political factors. Bureaucracies work slowly and are further slowed down by frequent change in personnel and election campaigns. Although the local IRH team had at times been influential in speeding up the bureaucratic process, it also had to work within existing political constraints to maximize the likelihood of institutionalizing SDM on a sustainable basis.

The resource team also seized opportunities. For example, scale up of SDM in Rwanda began at the time of major restructuring of government agencies, including the family planning department of the MOH. It was an opportune moment to integrate SDM into norms, protocols, and manuals that were being revised—a key strategy of institutionalization. During this time another USAID-funded project was working on pre-service training, thereby making it possible for the IRH resource team to work with this partner on integrating SDM into relevant curricula.

Taking country differences into account: The five countries where SDM is being introduced differ significantly in terms of size, population density, cultural diversity and level of economic development. For example, although Jharkhand is just one state in India, with 27 million people it has a larger population than Mali or Guatemala. Rwanda is relatively small and very densely settled, while the DRC has a large landmass and the population is widely dispersed. Cultural and linguistic diversity is particularly pronounced in Guatemala and Mali. In each country these factors have influenced the progress of SDM scale up.

Working in a large country like India meant having to deal with both the central-level MOH and the state-level health institutions which function with a considerable degree of autonomy. The central MOH was not always aligned with the state health and family welfare department regarding the relevance of SDM introduction, and this added to the level of bureaucratic complexity the team had to navigate; these were not issues that the IRH team had to deal with in smaller countries. On the other hand, a large and more industrialized country like India presents more opportunities for mobilizing support than smaller, resource-constrained countries like Mali or the DRC. India has enough potential users to justify local production of CycleBeads, and IRH was able to engage Hindustan Lifecare Limited (HLL) of India to manufacture CycleBeads for use in the family planning program.

The remoteness of some areas is another constraint. In the DRC it can take several days to reach some of the service delivery points and thus providers in these areas have limited contact with supervisors. In India, Jharkhand's relative remoteness and lack of infrastructure meant that it was difficult to attract stakeholders from other states to see what was being accomplished there and to motivate them to scale up SDM elsewhere in India.

Dealing with varying funding situations: The FAM Project is a USAID centrally funded project. However, to support the SDM scaling up process, IRH had to mobilize additional resources from within each focus country, either from the in-country USAID mission or other funding sources. Here between-country differences are large. In India IRH had successfully raised funds from the USAID Mission and the Government of Jharkhand, a reflection of an active local IRH resource team and champions in the donor agency. Moreover, the Government of Jharkhand could afford to fund training activities, thus enabling scaling to proceed more rapidly. This would not have been possible in the poorer focus countries.

In the three African countries there are more international organizations than in Jharkhand and by integrating SDM into their activities these organizations have helped to scale up SDM. This contrasts with the situation in Guatemala where the government lacks the resources to support introduction of SDM and where the USAID Mission and other donor support for family planning is very limited. Furthermore, when funding for family planning does become available to organizations, some are reluctant to use such resources for SDM scale up. Finally, even the limited funding available has been highly variable from one year to the next, creating uncertainty in terms of what scaling-up initiatives can be planned. Consequently, although potential demand for SDM may be considerable, realistic expectations and ongoing work with partners have been necessary.

Responding to professional bias against SDM: As IRH seeks partners to help it scale up SDM, it often encounters bias against the method on the part of some providers and agencies. Such bias has several causes. Even though SDM's effectiveness has been scientifically established,[i] and WHO and USAID include SDM in lists of modern methods, some professionals continue to associate it with ineffective traditional methods. Some also lack confidence in users' ability to learn and adhere to the method while others believe that it is too difficult to train community health workers to teach SDM to potential clients. Even if agencies know SDM is effective and feasible, they—and the donors who fund them—may favor long-acting and permanent methods and in addition fear that SDM will draw clients from among those currently using other effective methods.

The IRH team has dealt with these challenges both globally and in the five focus countries. A key strategy has been to disseminate widely the research evidence about SDM's effectiveness, its feasibility, its low demands on time for training providers and teaching clients, and its positive impact on recruitment of first-time users to family planning. Although its advocacy efforts to include SDM in family planning programs have been time-consuming, they have paid off in reducing bias and advancing the scale up of SDM with partners.

4. The resource team: supporting the process of scaling up

In the ExpandNet framework the resource team refers to the individuals and organizations that seek to promote and facilitate wider use of the innovation. The literature supports two key notions about the resource team. First, a dedicated team that facilitates the process of scaling up is one of the most important determinants of success. This is because scaling up, unlike routine program implementation,

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[i] With correct use the failure rate is 4.8%; with typical use 12.0%, which is comparable to condom use (*5*).

requires special attention until the innovation becomes thoroughly embedded within a program. Second, it is important that some members of the user organization(s) become part of the resource team (*1*). Whether they are formally appointed does not matter as long as members of the user organizations play an active role in providing support and guidance to the scaling-up initiative. Their involvement creates a sense of ownership of the innovation in the user organization and contributes to its sustainability.

IRH's approach reflected the importance of the resource team. In addition to IRH staff members in country and from headquarters, the resource team in the five countries consisted of key champions from the MOH and its NGO partners who actively supported the process of SDM scale up. In Mali, it was an MOH representative who consistently championed SDM introduction in the country. In Rwanda an MOH official who during the training expressed considerable skepticism about SDM, became a major champion after he had participated in several training sessions with IRH. In the DRC the leadership of a local

In Rwanda, a health provider offers SDM. [Photo Credit: IRH]

NGO was able, after initially receiving training support from IRH, to mobilize funding from another donor to support further training and supervision for SDM.

 At the same time, given the multiple responsibilities of MOH and NGO representatives these champions have also been constrained in what they could contribute. As a consequence, most of the work involved in scaling up SDM rested with the members of the relatively small IRH team. The trust they earned and their close coordination with the government were important determinants of the progress they made in scaling up SDM. For example, the Jharkhand IRH team chose to keep their office in the same building as the government even though they could have opted for better facilities. This proximity facilitated regular communication with members of the user organization and demonstrated that the IRH team was willing to share the same basic working conditions as their government colleagues. Such decisions reveal the importance of a broad range of skills in the resource team. In addition to technical skills such as training, skills in advocacy, networking, and strategic planning, as well as the ability to function in a bureaucratic environment, are essential. For example, in Rwanda the IRH team leader negotiated invitations to important MOH meetings where she could advocate for integrating SDM into the method mix. These approaches are not only strategic but necessary; since the small IRH teams have far less funding and staff compared to other international, bilateral and NGO organizations operating in the same country, they must leverage their limited resources.

5. Institutionalization: anchoring the innovation

To some people, scaling up simply means expanding a tested innovation to new sites or populations. But experience shows that such expansion will not be sustainable unless the innovation is institutionalized—anchored in policies, regulations, norms, budgets, training curricula or other national or sub-national institutional mechanisms (*3,18*). Whether such institutionalization proceeds quickly or slowly, or is extremely difficult to accomplish, greatly depends on the particular political, institutional and economic context.

Table 1 provides an overview of accomplishments in terms of institutionalizing SDM in the five focus countries by the end of the third year compared to the end-of-project target. It shows that overall the process of institutionalization has met and in some cases exceeded expectations. In terms of inclusion in key policies, norms, guidelines, and protocols, the DRC has already achieved its target and the other countries have made significant progress. In all countries except India SDM was included in national-level norms, protocols or policies; in India this was achieved within the state of Jharkhand, the focus of IRH activities. In the DRC, SDM was included in the Ministry's list of essential medicines and its contraceptive security plan; in Guatemala it was incorporated in the norms of the social security system (IGSS); and in Mali it became a component of the technical guidelines for midwives and training manuals for interpersonal communication and counseling. Table 1 also shows exceptions to these successes but in most instances there are no significant barriers to achieving the targets by the end of the project.

Inclusion of SDM in pre-service and in-service training curricula and in IEC materials is clearly important if it is to become fully integrated into routine family planning and health services. SDM inclusion in **in-service** training and IEC materials has progressed well, with the DRC accomplishing more than had been originally planned, but except for Rwanda, integration of SDM into **pre-service** training has been much slower. Professional training institutions are faced with a large variety of new information that should be included in their curricula but because it is a labor-intensive endeavor, they tend to revise curricula infrequently. They are often under the control of different ministries (for example the Ministry of Education) rather than the MOH and lack donor funding. In spite of such obstacles, in Mali SDM was integrated into the curriculum of the University of Mali School of Medicine, the National Institute of Health Science Training and a nursing school[i] and in Rwanda IRH already had reached its target of integration into five institutions, including in a nursing school and a health institute.[ii]

Table 1. Institutionalization of SDM in five countries by year 3 accomplishments and 6 year targets (N)					
SDM included in:	DRC	Guatemala	Jharkhand (India)	Mali	Rwanda
Policies, norms, guidelines, and protocols	6/6	3/6	2/3	7/8	3/4
Pre-service training and/or continuing education	0/4	0/2	0/3	3/38	5/5
In-service training	21/17	11/12	4/6	11/11	6/9
IEC activities, materials and mass media	5/4	4/6	2/4	5/8	11/12
HMIS/reporting systems	9/11	2/3	1/2	0/1	1/1
Sustainable inclusion of CycleBeads into:					
Donor procurement systems	1/3	0/2	0/1	1/3	2/2
Logistics systems	1/1	0/4	1/1	2/2	6/6

[i] The number of pre-service institutions into which SDM is to be integrated in Mali is large because once it is integrated into the coordinating national-level academic body (INFSS) it must be adopted individually by the 38 schools of public health, health sciences, medical schools, nursing and pharmacies throughout Mali.
[ii] Success in Rwanda was accelerated by the USAID-supported Capacity Project which had the mandate to revise family planning normative and training documents; they worked closely with IRH to embed SDM in these documents.

Making changes in the HMIS is often a lengthy and costly process. In spite of this, integration of SDM into the HMIS has progressed well in the five countries. As with the other categories of institutionalization, the number of HMISs in which SDM was to be included varied by country. For example, the DRC is in the process of developing an HMIS from the health centers up to the national level, which has provided an opportunity to include SDM. At the end of the third year, inclusion in nine of the eleven provinces had been achieved. In Rwanda, inclusion of SDM in the Ministry's HMIS was completed. In Jharkhand, SDM is not officially in the Ministry's reporting system, but the data are collected in hand-written columns on the existing forms. In Mali, while SDM has not yet been included in the MOH monitoring system, the MOH has agreed to add SDM in the forthcoming revision of its health reporting form.

The availability of CycleBeads is also critically important. In three of the five countries CycleBeads are now included in the logistics system and also in three countries SDM is part of a donor procurement system; in India IRH has negotiated CycleBeads procurement through the private sector. Procurement in Guatemala remains uncertain as United Nations Population Fund (UNFPA) procures contraceptive methods for the country and has thus far declined to include CycleBeads, even though the MOH has ordered them.

Institutionalizing SDM within national programs shares with other family planning methods a set of ongoing challenges. Sustainable provision of SDM, even if integrated into the national program, depends on external donor funding in many countries for training, mass media dissemination, and CycleBeads procurement. In addition, even if SDM were adequately funded and institutionalized, it needs a good supervision system to oversee its implementation. However, public sector supervision is often weak, infrequent and tends to emphasize administrative control. To partially address this serious challenge, local IRH teams often provide transport to supervisors and encourage them to use IRH's job aid for supportive supervision.

6. Expansion of SDM to new sites

Expansion involves strategic choices about how to disseminate an innovation to new service delivery sites and to new population groups.

Expanding the supply-side: Building the capacity of service delivery systems to expand SDM availability has been the chief strategy in each of the five focus countries. This has involved training trainers and providers in both the public sector and collaborating NGOs, providing IEC materials and ensuring availability of CycleBeads. Table 2 below gives an overview of the targets and accomplishments of the expanded availability of SDM.

Table 2. Expansion of SDM in five countries by 3rd year accomplishments and 6 year targets (N)

	DRC	Guatemala	Jharkhand (India)	Mali	Rwanda
Service delivery points that include SDM as part of the method mix	539/762	132/308	1011/2100	880/1184	687/690
Estimated number of individuals trained to counsel clients in SDM (IRH supported) by: • Male • Female • Total	243 173 416/1,140	313 1,048 1,361/1,809	450 5,350 5,800/15,000	1,455 4,367 5,822/7,000	821 2,021 2,842/5450
Ratio of facility-based personnel trained with IRH support to SDM service delivery points	.77*	10.3**	5.7	6.6	4.1
Number of organizations that have capacity to undertake SDM activities	21/23	10/18	3/8	13/13	8/8

* In DRC the number is artificially low because much of the training was done by partner organizations and not included in these figures.
** In Guatemala, the number is artificially high because personnel from facilities not yet offering SDM were also trained.

Each country has defined different objectives for scaled-up service delivery of SDM, based on the level of resources, the timeframe available and the general country context. In Rwanda, which is relatively small and has strong bilateral donor support for family planning and MOH commitment to revitalize services, national level expansion of SDM was planned. In Mali, by contrast, the northern province of the country had to be excluded due to its remoteness and political instability. In the DRC, SDM expansion was coordinated with the MOH's post-conflict effort to reestablish health services; this process determined the pace of expansion throughout the country.
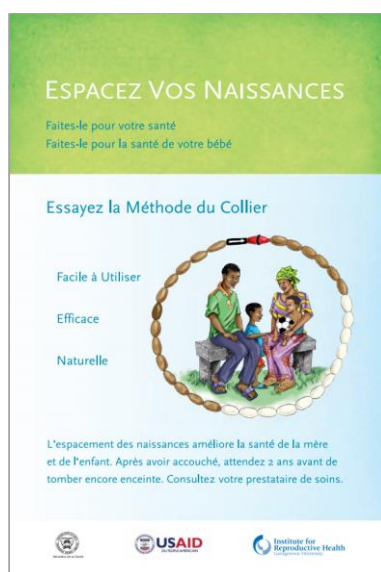
IRH considers SDM integrated into service delivery when at least one staff member at a service delivery point has been trained, CycleBeads are available, and a system for recording SDM use is in place. Over the three-year period of the FAM Project considered here, SDM became available in numerous service delivery sites, although the extent of expansion varies significantly by country (Table 2). Jharkhand has the largest number of service delivery points offering the method, Guatemala the smallest. Service delivery points included hospitals, health posts or centers, private clinics, and villages in the case of community-based programs. The ratio of IRH-trained personnel to SDM service delivery points ranged between 4.1 and 6.6 except in the DRC and Guatemala which represent special cases. In the DRC, NGO partners did much of the training and those trainees are not included in the ratio; in Guatemala many providers who had been trained in SDM were working at facilities where the method was not offered. A

key lesson from Guatemala is that training alone does not lead to expanded availability of SDM services. Based on the extent of training and related interventions, MOH leaders assumed that SDM was widely available in public health services throughout the country. However, fieldwork conducted as part of a strategic planning exercise found that this was not the case. MOH leaders therefore decided to focus on providing SDM in only three of the 22 administrative subdivisions of the country to learn how it could be effectively scaled up in the public sector.

Expanding the demand-side: IRH leadership recognized from the outset that attention to demand-side interventions is equally important. Availability of SDM in a variety of service delivery sites, by itself, is insufficient to ensure significant uptake of the method. The resource team had to create awareness among the general public about the method's existence, its effectiveness, how it works, and where CycleBeads and counseling are available.

In the five countries the project worked through various channels using television and radio spots, community radio programs, posters and other IEC initiatives. What was done depended largely on the opportunities that were available through partner organizations. In addition, in all the countries community health workers from the public and/or the NGO sector were trained to create awareness and

Posters—like this one from Mali—and other IEC initiatives helped create awareness of SDM among the public.

demand for SDM and to explain the method appropriately. Overall, demand-creation efforts were small, limited by insufficient funding or technical capacity to undertake a strategic, coordinated and comprehensive SDM information campaign. IEC activities and results varied by country: the two household surveys conducted at the midpoint of the FAM Project found that awareness of SDM in project areas in Mali was 79% of women and 71% of men, but in Guatemala, only 24% of women and 26% of men.

The best test of demand-creation is use of the method. At this midway point, data on SDM actual use for the five countries are limited and mostly based on CycleBeads sales and service statistics, which are usually less reliable than surveys. Factoring in these limitations, IRH estimates that in the first three years of the FAM Project, over 115,000 new users were registered in public sector service statistics or reported by partner organizations and 461,000 CycleBeads had been procured for the five countries.[i] Given use estimates in each country, data from two surveys and observations made during field visits, the IRH team concluded that more attention to demand-creation is required in the remaining half of the FAM project and that this will require additional fundraising to support these activities. The impact of a greater focus on demand-creation among communities and couples will be assessed through planned endline surveys in all five countries prior to the end of the study.

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[i] This figure does not include CycleBeads procured by the Indian Hindustan Latex Limited company.

Conclusions

Among the many lessons that emerge from the experience of scaling up SDM introduction in five focus countries, three are paramount. The first relates to training, the second to the balance between working on the supply-side of services versus demand-creation for SDM, and the third to the central role of the resource team.

Training of trainers and training of providers are essential tasks in scaling up the introduction of any new method of family planning. However, training alone is not sufficient to achieve large-scale availability, as was particularly apparent in Guatemala. Commensurate attention must be given to other important components of service delivery such as strengthening the supply chain and the supervision system, and incorporating the method into existing IEC materials, supervision protocols and the HMIS.

The second major lesson concerns the balance between expanding the availability of services that offer the new method and creating awareness and demand for it in the community. The first three years of the project were more focused on building the supply side. However, based on estimates of actual use of SDM and data showing that awareness of SDM was still low in one of the two project settings for which data are available, the IRH team concluded that more needs to be done to increase demand for the method in the remaining years of the project. The lesson is that strategic thinking about and resource mobilization for both demand-side and supply-side investments are equally important parts of planning and managing the scaling-up process.

We conclude with a third lesson. Scaling up of a health innovation requires the concerted efforts of a dedicated resource team until the innovation is widely known at the community level and has become sufficiently integrated into a program that it is part of routine service delivery. Scale-up does not take place spontaneously following a successful pilot test. As this paper has shown, a great deal has been accomplished in terms of institutionalizing SDM within the five country programs and making it more widely available at service delivery points. This would not have been achieved without the creative and sustained effort of the resource team that has guided the process.

References

1. ExpandNet and World Health Organization. Practical guidance for scaling-up health service innovations. Geneva, World Health Organization; 2009.
2. Simmons R, Fajans P, Ghiron L, Eds. Scaling up health service delivery: from pilot innovations to policies and programmes. Geneva, World Health Organization; 2007.
3. Cooley L, Kohl R. Scaling up – from vision to large-scale change: A management framework for practitioners. Washington, DC, Management Services International; 2006.
4. Walt G, Gilson L. Reforming the health sector in developing countries: the central role of policy analysis. Health Policy and Planning, 1994. 9:353-370.
5. Arévalo M, Jennings V, Sinai I. Efficacy of a new method of family planning: the standard days method. Contraception 2002, 65:333–8.
6. Gribble J. The Standard Days Method of Family Planning: A Response to Cairo. International Family Planning Perspectives, 2003. 29(4):188-91.
7. Gribble J, Lundgren R, Velasquez C, Anastasi E. Being strategic about contraceptive introduction: the experience of the Standard Days Method®. Contraception, 2008. 77:147-154.
8. Rogers E. Diffusion of innovations, 4th ed. New York, Free Press; 1995.
9. Simmons R, Shiffman J. Scaling up health service innovations: A framework for action. In Simmons R, Fajans P, Ghiron L, eds. Scaling-up health service delivery: from pilot innovations to policies and programmes. Geneva, World Health Organization, 1–30; 2007.
10. Sinai I, Lundgren R, Arévalo M, Jennings V. Fertility awareness–based methods of family planning: predictors of correct use. International Family Planning Perspectives, 2006. 32:94–100.
11. Sinai I, Jennings V, Arévalo M. The importance of screening and monitoring: the Standard Days Method and cycle regularity. Contraception, 2004. 69:201-6.
12. Lundgren R, Naik S, Johri L, Sood B, Jennings V. Expanding contraceptive prevalence in India through fertility awareness-based methods of family planning. Obstetrics & Gynaecology Today, 2007. XII(9):426-430.
13. Fajans P, Nguyen TT, Whittaker M, Satia J, Phuong Mai TT, Dinh Can T, Thanh Nhan DT, Newton N et al. Strategic choices in scaling-up: introducing injectable contraception and improving quality of care in Viet Nam. In: Simmons R, Fajans P, Ghiron L, eds: Scaling-up health service delivery: from pilot innovations to policies and programmes. Geneva, World Health Organization; 2007.
14. Atun R, de Jongh T, Secci F, Ohiri K, Adeyi O. Integration of targeted health interventions into health systems: a conceptual framework for analysis. Health Policy and Planning 2009, 1– 8.
15. Gericke C, Kurowski C, Ranson MK, Mills A. Intervention complexity – a conceptual framework to inform priority-setting in health. Bulletin of the World Health Organization, 2005. 83:285-93.
16. Greenhalgh T, Robert G, Macfarlane F, Bate P, Kyriakidou O. Diffusion of innovation in service organizations, systematic review and recommendation. Milbank Quarterly, 2004. 82:281-629.
17. Peters D, Garg A, Bloom G, Walker D, Brieger W, Rahman MH. Poverty and access to health care in developing countries. Annals of the New York Academy of Sciences, 2008. 1136:161-71.
18. Hartmann A, Linn J. Scaling up: a path to effective development. 2020 FOCUS BRIEF on the World's Poor and Hungry People, 2007. Washington, DC: IFPRI.
19. ExpandNet and World Health Organization. Nine steps for developing a scaling up strategy. Geneva, World Health Organization; 2010.
20. Fixsen D, Naoom S, Blase K, Friedman R, Wallace F. Implementation Research: A Synthesis of the Literature. University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231); 2005.