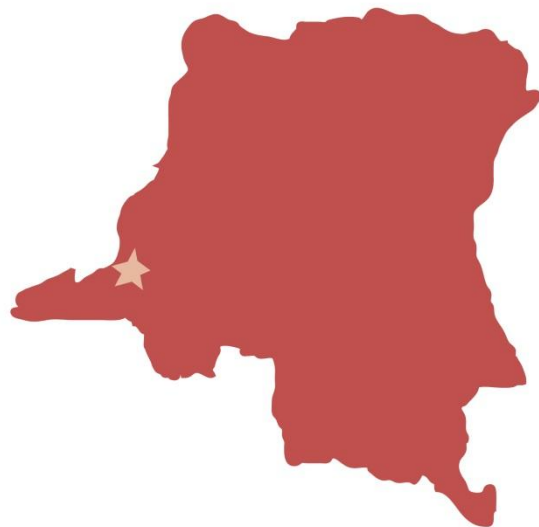


SCALE-UP OF STANDARD DAYS METHOD® IN DR CONGO

C O U N T R Y B R I E F



USAID
FROM THE AMERICAN PEOPLE



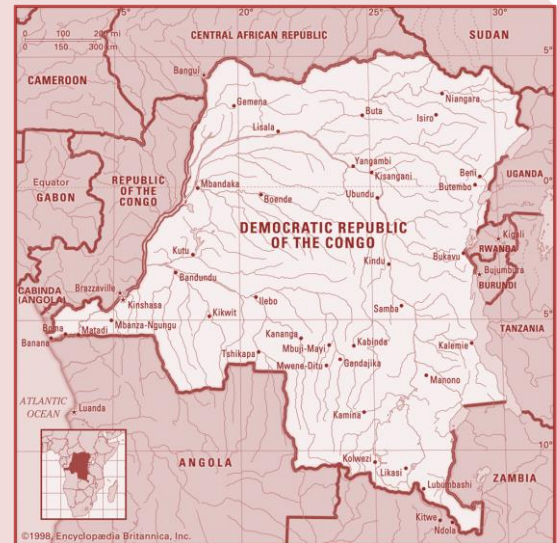
Since the early 2000s, the Institute for Reproductive Health at Georgetown University (IRH) has introduced and tested the Standard Days Method® (SDM) in a variety of service delivery settings around the world. IRH and partners are now scaling up SDM services in family planning (FP) programs in the Democratic Republic of Congo (DRC), Guatemala, India, Mali, and Rwanda.

This report summarizes events in DRC, including choices, approaches and results of systematic SDM scale-up and related research. It concludes with an analysis of factors that influenced scale-up.

By 2003, when IRH introduced SDM in the DRC, several donor-funded programs had begun the work of revitalizing public health services after decades of weak oversight, underfunding, corruption and—since the onset of war in the early 1990s— neglect. The task was not made easier by the vastness of the country and its near-total lack of transportation and communication infrastructure. A newly created National Program for Reproductive Health (PNSR) within the Ministry of Health (MOH) represented the government’s willingness, if not its capacity, to address high rates of population growth, total fertility, and maternal and infant mortality. IRH began its SDM program in DRC at the invitation of USAID, a strong champion of FP as an essential element of revitalized, basic health services.

The DRC health system has three levels: central, intermediate or provincial, and peripheral. The latter comprises 515 health zones and more than 6,000 facilities. Service delivery in about half of all health zones is supported by faith-based and/or nongovernmental organizations (FBO, NGO), but even with this support, the system struggles to overcome weaknesses in supplies and logistics, staff, training, supervision, and financing.

A 2003 qualitative study in Kinshasa demonstrated an interest in effective, low-cost FP methods without side effects, suggesting a potential fit for SDM. Moreover, the DRC’s strong religious culture and active role of the church in health service delivery boded well for SDM acceptance.



Map: Adapted from vidianimaps.com

DRC AT-A-GLANCE

CURRENT POPULATION:	67 million
POPULATION GROWTH RATE:	2.7% per annum
GDP PER CAPITA, 2012:	\$231
TOTAL FERTILITY RATE, 2011:	5.65
CONTRACEPTIVE PREVALENCE, WOMEN AGES 15-49, 2010:	17.3%
UNMET NEED FOR CONTRACEPTION, MARRIED WOMEN AGES 15-49, 2007:	24.4%
MATERNAL MORTALITY RATIO PER 100,000 LIVE BIRTHS:	550
INFANT MORTALITY RATE PER 1,000 LIVE BIRTHS:	110.6

Sources: World Bank World Development Indicators

INTRODUCTORY PHASE 2003-2007

HOW SUCCESSFUL WAS SCALE-UP OF SDM IN DRC?

As of December 2012:

SERVICE EXPANSION

SDM services are available in 283 health zones (55% of health zones in DRC)

26 organizations and MOH have capacity to promote and offer SDM

INSTITUTIONALIZATION

Integration into national FP program and sub-systems completed for:

- Norms, policies, guidelines
- SNIS FP Reporting
- In-service training curricula
- Logistics system
- MOH-sanctioned IEC materials

SDM USERS & KNOWLEDGE OF SDM OPTION

SDM users comprise 15.4% of all FP users; most had used the method more than 6 months

Primary reasons former users stopped using SDM included pregnancy, loss of CycleBeads, fertile window too long

Awareness of SDM: 37.3% for women, 24.6% for men

IRH's early objective was consistent with USAID's request to establish and extend, as widely as possible, SDM services in DRC. IRH strategy centered on extending its small staff's reach and impact by *forming partnerships* with organizations that already managed health services in the field (MOH, FBOs, NGOs) and *providing technical assistance* to those partners. Training, especially via training of trainers, advocacy for SDM, review of key documents and research support were critical components of technical assistance.

By the close of the introductory phase, IRH had developed solid relations with 14 organizations, including PNSR, NGOs, donors and their large-scale health revitalization programs, a social marketing firm, and several FBOs. Almost all of these partners had the capacity not only to provide SDM services and counseling to clients, but to train other organizations to do so.

Research by IRH and others during this period found high levels of interest in and acceptance of SDM by service providers, users and their partners. SDM was also judged appropriate for social marketing. IRH provided technical advice for—and ensured SDM's inclusion in—the DRC's *in-service FP training manual* for providers, and the new *national reproductive health (RH) norms*.

By the end of the introductory phase, IRH had strong evidence of the following:

- SDM's acceptability in DRC,
- potential for increased demand, and
- PNSR's support for the method.

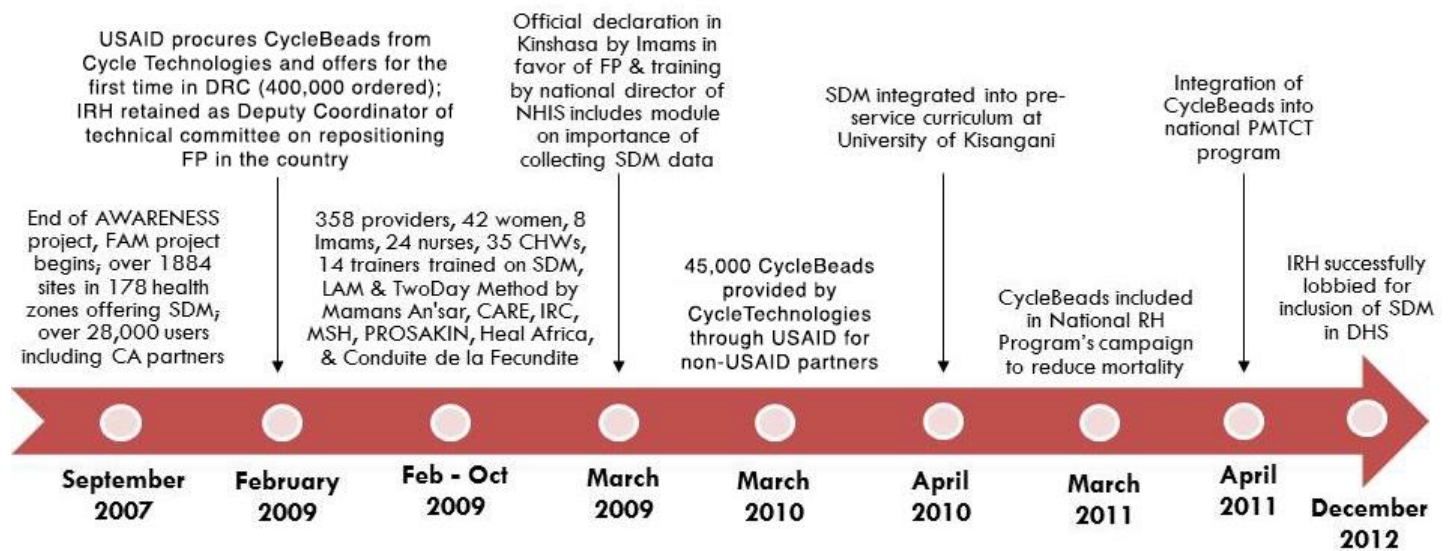
IRH launched a scale-up phase to increase access and availability, and to further institutionalize the method in DRC.

SCALE-UP PHASE 2007-2012

IRH used the WHO/ExpandNet framework to plan SDM scale-up in DRC and developed these objectives:

HORIZONTAL OBJECTIVES	VERTICAL OBJECTIVES
<ul style="list-style-type: none"> Expand geographic coverage to reach at least 300 of the country's 515 health zones. Maintain existing partnerships (14) to ensure geographic coverage and continued quality of services, and to build capacity for SDM training. Develop partnerships with organizations in new project areas. 	<ul style="list-style-type: none"> Integrate SDM into policies, plans, guidelines. Integrate SDM into the national and provincial health information system (SNIS). With partners, integrate SDM into Ministry of Education's pre-service curriculum for nurses. Ensure IEC Unit within MOH includes SDM in materials. Ensure MOH and USAID collaborating projects include SDM in FP programs. Mobilize resources from donors for programmatic and commodity support for SDM.

As during the introductory phase, IRH maintained a relatively small footprint in DRC during scale-up. The major activities of its small staff (two technical staff) were networking, alliance-building, advocacy and provision of TA.



USING DATA TO GUIDE SCALE-UP

Routine monitoring data, punctuated by several types of evaluation helped IRH track SDM scale-up, identify problem areas, inform decision makers about SDM's success as it became part of routine service delivery, and reinforce movement towards a common goal among scale-up actors.

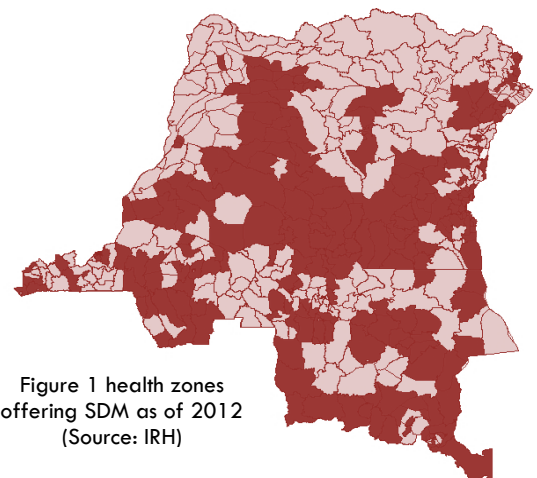


Figure 1 health zones offering SDM as of 2012 (Source: IRH)

MONITORING SDM EXPANSION: The SDM scale-up phase in DRC did not include a baseline assessment. As scale-up implementation proceeded, though, IRH did collect information to guide the scale-up process. First, in-depth interviews with 23 stakeholders in 2009 confirmed high support of SDM scale-up among all key actor groups (MOH, donors, FBOs and religious leaders, NGOs) and elicited analysis of how IRH should maneuver within DRC’s complex socio-political environment to best achieve its objectives. Second, a mid-term survey of 154 providers in six health zones examined the extent of SDM availability (71% of providers offered SDM in the 12 months leading up to the study), service quality (over 75% of providers correctly answered questions about SDM and use of CycleBeads®), and record-keeping (almost 90% recorded SDM in FP registers; almost 78% reported SDM in monthly SNIS).

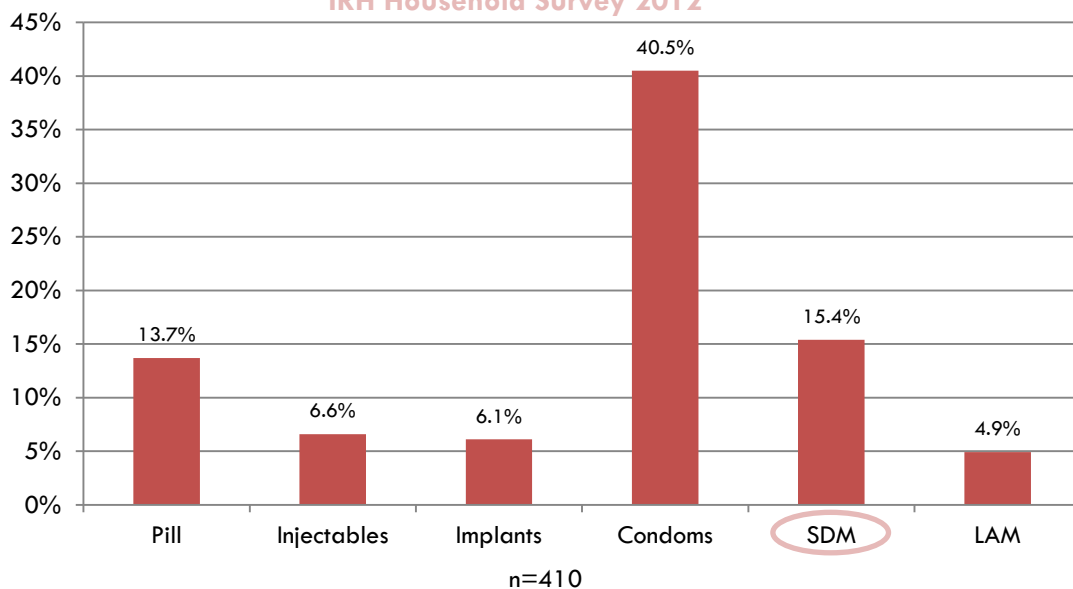
ASSESSING THE STATUS OF SDM SCALE-UP: Finally, IRH conducted a two-part endline evaluation in DRC in 2012 to assess changes in the socio-political environment vis-à-vis SDM expansion, gain a population-based estimate of the number of SDM users, and understand the factors that influence community demand for SDM, including awareness, attitudes, and perceptions of SDM among women and men:

Stakeholder interviews revealed especially strong awareness of geographic expansion of SDM services and of IRH’s coordination, advocacy and support role. Respondents tended to have a weaker grasp of the importance of vertical scale-up (policies and normative documents) to achieve sustainability, although many knew of or participated in SDM institutionalization in one or more ways. Most stated that service providers’ perception of SDM was ‘generally good’ or ‘very positive.’

A household survey solicited information from 2,397 women and men from 1200 households in six health zones across DRC, both rural and urban. The results indicated that IRH and its partners were successful in increasing awareness of SDM and men and women recognized its affordability, ease of use (self and partner), lack of side effects, religious compatibility, and accessibility. SDM use rates were significant: Among users of FP methods, over 15% of women chose SDM. Of note is that both current and former users of SDM (93%) reported being satisfied with SDM and more than half found SDM to be effective and acceptable to their partners. 37.3% of women and 24.6% of men had heard of SDM.

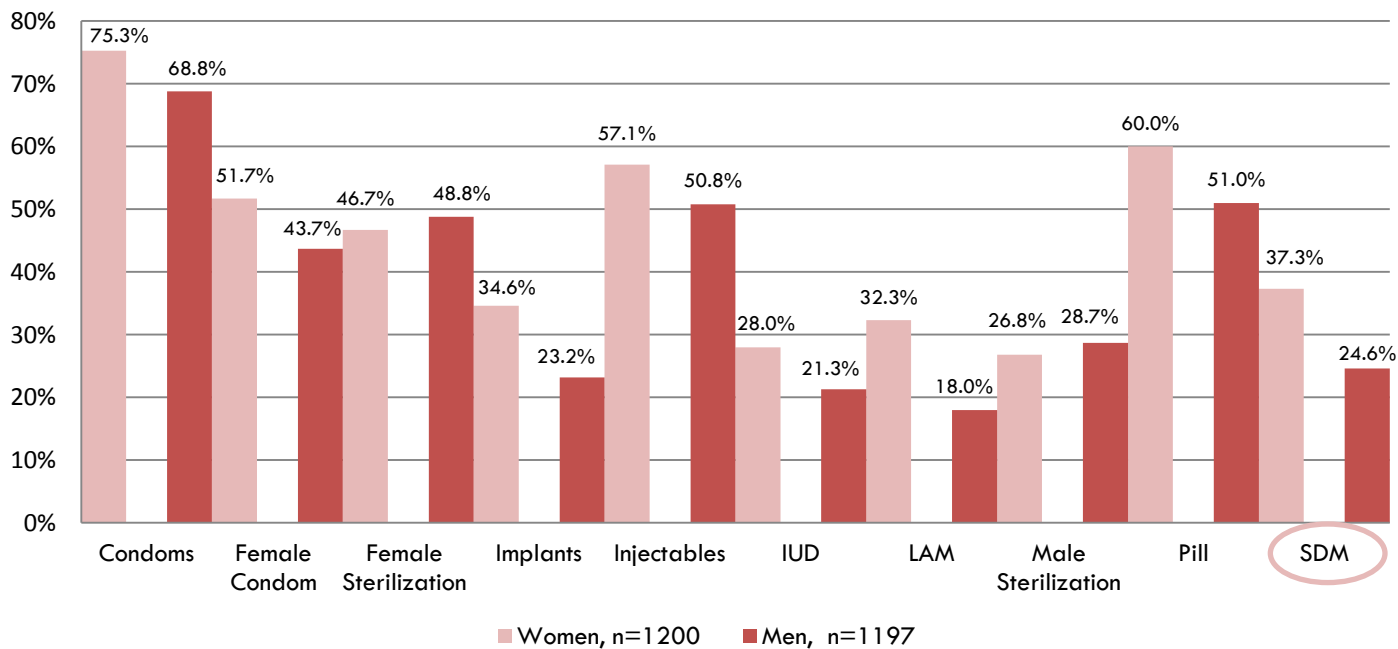
METHOD USE AMONG WOMEN CURRENTLY PRACTICING FAMILY PLANNING

IRH Household Survey 2012



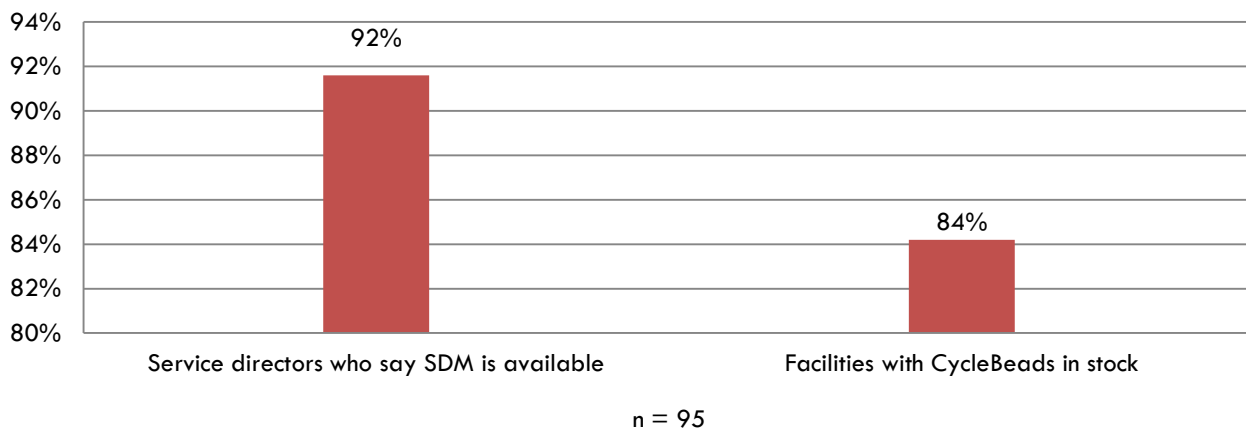
PERCENTAGE OF WOMEN AND MEN WHO KNEW OF FAMILY PLANNING METHODS

IRH Household Survey 2012



SELECTED SERVICE PROVISION RESULTS

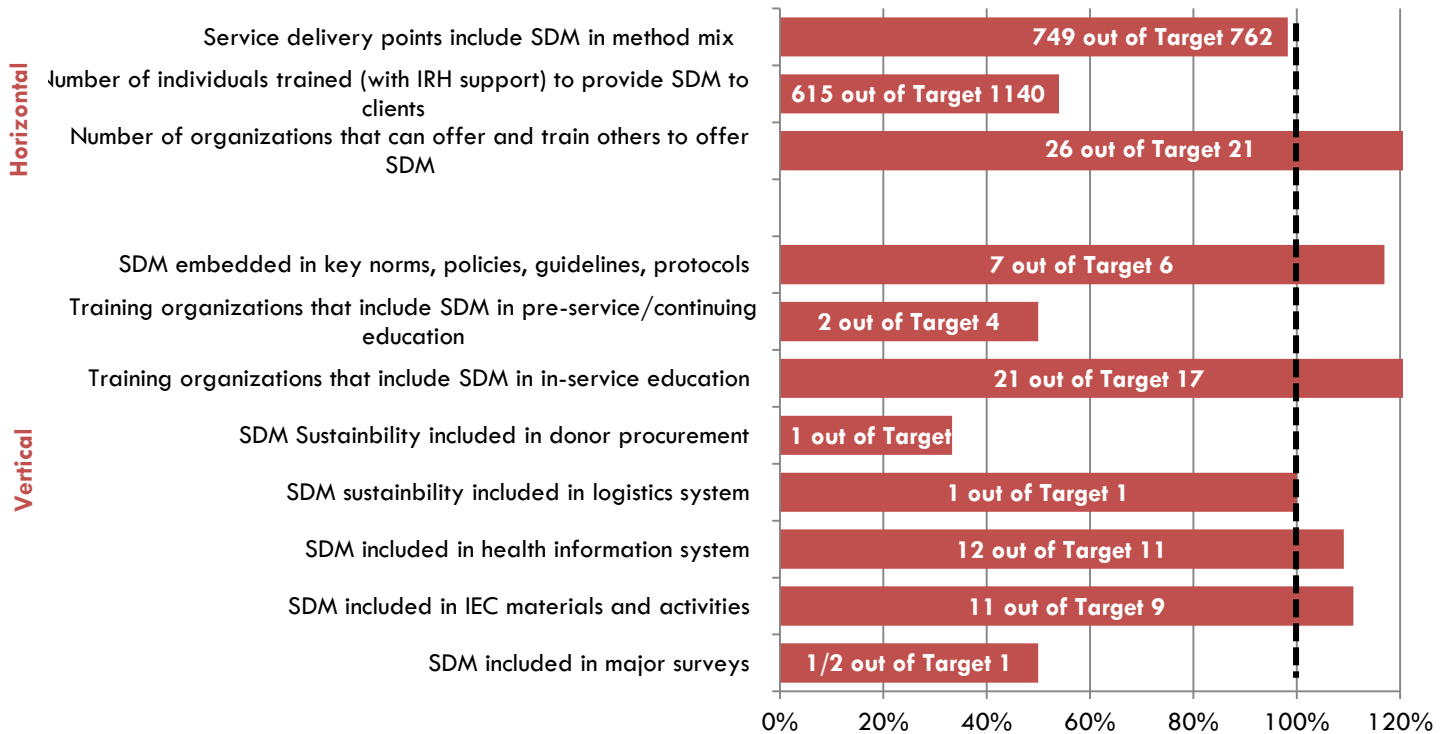
IRH Facility Survey 2011



ACHIEVEMENT OF SDM BENCHMARK TARGETS

The table below shows IRH’s overall achievements of benchmarks in DRC, for horizontal and vertical indicators. Benchmarks are then briefly discussed.

PROPORTION OF BENCHMARKS ACHIEVED, DRC



By the end of scale-up in DRC:

- **749 service delivery points included SDM in their method mix**
- **More than 600 providers had been trained in offering SDM**
- **26 organizations had the capacity to further SDM expansion**

IRH’s work along the *horizontal* scale increased availability of and provider capacity to offer SDM across the DRC. By the end of the scale-up phase, 749 service delivery points (over 98% of target) included SDM in their method mix. Unexpected funding cuts meant that IRH could not directly train as many providers as intended, but did train more than 600, representing 54% of the target number. Moreover, the pool of trainers integrated SDM into their ongoing training of others, independent of IRH support. Ultimately, twenty-six organizations (124% of target) in DRC had the capacity to further SDM expansion by the close of the scale-up period.

Activities on the *vertical* scale aim towards SDM’s sustainable institutionalization in DRC’s FP program and its RH service standards. SDM is now included in seven crucial guiding documents (one more than planned), including revised Norms and Policies, Commodity Security Plan, list of essential medicines, and revised national FP training manual. SDM is also embedded in the strategically important pre-service manual for secondary-level nurses (who deliver some 80% of health services in DRC), and in the MOH’s in-service FP training curriculum for all providers. Several NGOs use the same in-service materials in their health programs.

USAID worked with Cycle Technologies, the manufacturer, to integrate CycleBeads into its procurement system in DRC but the other two targeted donors, UNFPA and MOH (categorized as such because it requests commodities from donors) did not. Because a national logistics system for health commodities does not exist in DRC, IRH targeted USAID's system to include SDM. USAID ultimately ordered a total of 550,000 sets of CycleBeads from Cycle Technologie for DRC during the scale-up period; of these, IRH took charge of 45,000 and distributed them to implementing partners not funded by USAID and thus not eligible to receive commodities directly from USAID.

DRC was overhauling and decentralizing its health information system (SNIS) while SDM scale-up was underway. IRH advocated for and provided significant TA to include SDM as a distinct category in FP data collection tools in ten of DRC's eleven provinces. IRH also exceeded its target for IEC activities and materials and provided ample support to both the MOH and private organizations (FBOs, NGOs and social marketers) in this regard. Finally, IRH worked for SDM's characterization as a distinct method (not combined with 'natural' or 'other' FP methods) in the Demographic and Health Survey, but counted only partial achievement of the target because the survey was delayed until 2013, after the scale-up phase ended.

SCALE-UP AND THE DRC ENVIRONMENT

The DRC's complex and unstable environment provided obstacles as expected, but also several opportunities, which IRH leveraged for successful SDM scale-up. The vast country has poor infrastructure and weak institutions, and governmental support for FP and RH, while clear on paper, is not sufficiently expressed in support and funding for service delivery. On the other hand, health services in about half of DRC's health zones are managed or supported by FBOs and NGOs and backed by donor agencies that are typically keen to promote RH, including not only service provision but the policies, procedures and guidelines needed for quality and sustainability. IRH's chosen strategy to work through partners (government, donor, NGO, FBO) offered ample opportunity to support FP revitalization overall and to guide and improve system elements, while ensuring SDM integration.

IRH's chosen strategy to work through partners—including the government, donors, NGOs, and FBOs—offered ample opportunity to support FP revitalization overall, and to guide and improve system elements, while ensuring SDM integration.

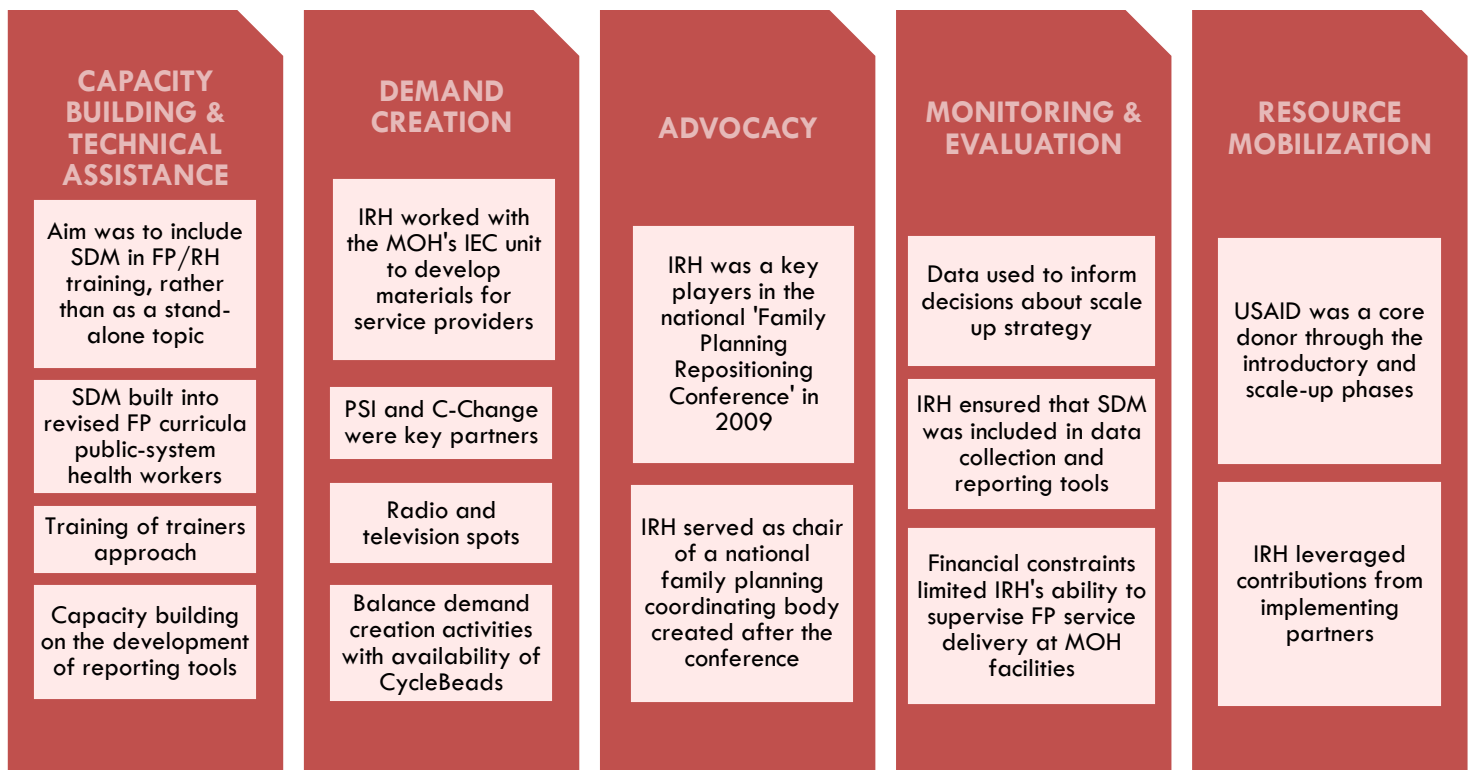
In DRC's donor environment, USAID was the most supportive of SDM expansion, though it did withdraw partial IRH funding that supported field work in late 2009. UNFPA (which, together with USAID, is the major FP commodity donor in DRC) and World Bank (a funder of large-scale health revitalization programs) did not take steps to procure CycleBeads for their projects. Incongruously, they and/or their implementing agencies approached IRH at times for CycleBeads to meet client demand in their project zones. In endline interviews, several stakeholders noted the need to involve other smaller donors such as the European Union and the Belgian technical agency that fund health programs in health zones where SDM is not yet available.

DRC's sociocultural environment held both facilitating and limiting factors for SDM scale-up. On one hand, ingrained gender/power roles and deep religious convictions are linked to a high fertility rate. On the other, SDM's attributes as a natural FP method that involves both women and men in its use meant it found favor, especially within the influential Catholic church (notably, via the FBO *Conduite de la Fécondité*) and to a smaller, yet important, degree among Muslims in Kinshasa (notably, via the FBO *Mamans Ans'ar*).

RESOURCE AND USER ORGANIZATIONS

As noted, IRH's strategy was to expand its reach and impact by working through partnerships with donor agencies, government agencies, institutions, NGOs and FBOs. A large number of such organizations gained the capacity to provide SDM services, typically within FP/RH programs that were strengthened overall as a result of IRH TA; these are referred to as 'user organizations.' At the end of the scale-up period, 26 entities were also 'resource organizations.' This means they could train and supervise others to offer SDM. They could also (variously) adapt training content, develop IEC items, create demand, facilitate information-sharing and mutual capacity-building among peers, and (in some cases) support health sector reform including FP and RH, and fund new FP programs, including SDM, to DRC's reformed standards.

STRATEGIC CHOICE AREAS



The ExpandNet model guides users to make strategic choices in several areas based upon their operating environment. These areas, as they applied to SDM scale-up in DRC, are briefly summarized here and in the graph above.

CAPACITY BUILDING AND TECHNICAL ASSISTANCE: IRH's multi-organizational, participatory approach in the DRC focused heavily on TA and capacity building. Its approach to training service providers was comprehensive. First, the aim was to include SDM in FP/RH training and not treat it as a stand-alone topic. Second, IRH built SDM into revised FP curricula—both in-service and pre-service—for public-system health workers (especially but not exclusively secondary-level nurses), the MOH's community-based health workers (*relais*), specialized workers such as pharmacists linked to social marketing projects, and FBO counselors. The curricula work entailed extensive consultation with and support of MOH's various education divisions but also institutions such as the University of Kinshasa Faculty of Medicine. Third, IRH used a training-of-trainers approach and hence

built a pool of individuals and organizations in DRC able to train others in FP and SDM service delivery. Finally, IRH provided specialized capacity-building, such as training staff involved in contraceptive method forecasting and—for the SNIS—in development of reporting tools.

DEMAND CREATION: IRH worked with the MOH’s IEC unit to develop an array of materials for service providers, including a DRC-tailored calendar and user instructions card, a supervision tool and provider checklist, and a memory aide card. PSI and C-Change were key partners in creating posters, flyers and illustrated flip charts. IRH and partners also developed radio and television spots. Insufficient human and financial resources within the DRC were, not surprisingly, constraints to demand creation. Yet IRH found that it had to balance demand creation (due to low awareness of SDM) with supply of CycleBeads (and providers able to offer it): especially in zones not supported by USAID, it was counterproductive to raise demand that could not be met.

ADVOCACY: Advocacy was a continuous activity for IRH in DRC. IRH was a key player in the 2009 national ‘FP Repositioning Conference’; one result of that conference was the creation of a national FP coordinating body, of which IRH served as chair. Until recently, the body was stymied by lack of funding, yet the position put IRH at the center of information-sharing, debate and decision-making. IRH noted that advocacy was still needed in the arenas of SDM commodity security and expansion of public-private partnerships to meet the high proportion of people who obtain FP methods from the private sector.

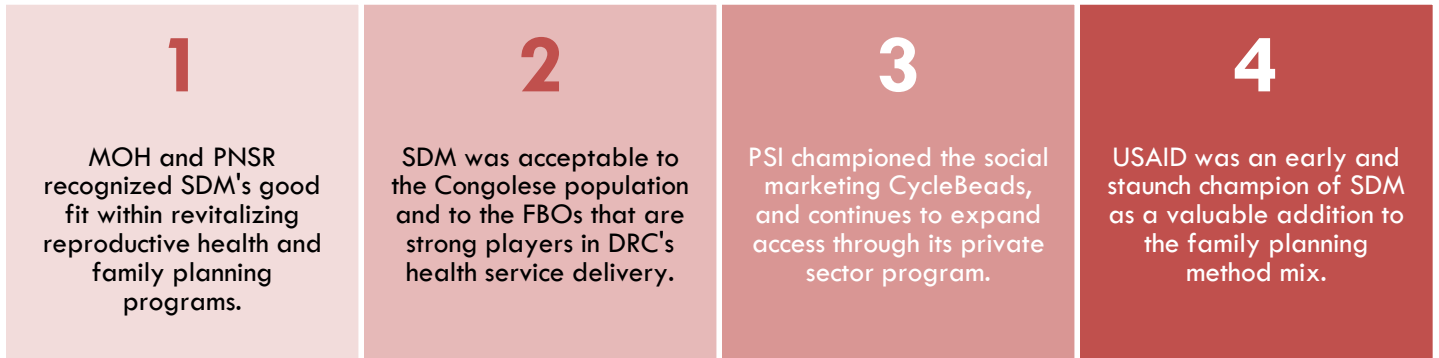
MONITORING & EVALUATION: The type and sources of data that IRH used in DRC are discussed above. Regarding M&E *process*, it is worth noting that IRH:

- Made use of data for decisions related to scale-up strategy and tactics. For example, data gathered by IRH determined that the quality and effectiveness of SDM training remained acceptable after reducing the length of training from five days (as a stand-alone session) to less than a half-day (as an integrated module in FP training). IRH used data monitoring CycleBeads stock-outs to develop new strategies to obtain sets and provide them to users.
- Took advantage of the SNIS revitalization and decentralization process, which coincidentally was underway during SDM scale-up, to ensure SDM’s inclusion in data collection and reporting for all health zones to provincial level.
- Was not able to support and participate in supervision of FP service delivery at MOH facilities to the extent desired, due to financial limitations.

RESOURCE MOBILIZATION. USAID was IRH’s core donor throughout the introductory and scale-up phases. The ending of its field support funds in 2009 reduced IRH’s ability to provide direct TA and other support except in Kinshasa. IRH continuously sought other sources of funding, and was most successful in leveraging contributions to scale-up activities from its implementing partners. For example, it was quite common for NGOs and FBOs to co-fund or contribute in kind to training sessions, IEC materials, and even purchase of CycleBeads directly from Cycle Technologies or via USAID procurement mechanism.



KEY ELEMENTS THAT FACILITATED SCALE-UP IN DRC



IRH's work in DRC benefited enormously from the fact that SDM, as a method, was a good match for DRC's technical, donor, and sociocultural environment:

1. MOH and PNSR recognized SDM's good fit with its program to revitalize RH and FP, and accepted the method readily. The PNSR director had been seeking a new, natural FP method to respond to unmet need, and was a strong advocate for SDM among her peers. Evidence suggests that MOH service providers found the method easy to offer to clients.
2. The method was acceptable to the Congolese population and to the FBOs that are major players in health service delivery in DRC.
3. PSI championed the social marketing of CycleBeads and continues to expand access through its private-sector.
4. USAID was likewise an early and staunch champion of SDM as a valuable addition to the FP method mix. USAID advocated for the role that IRH could—and did—play by piggybacking on SDM integration to strengthen FP services as a whole.

IRH appreciated and made the most of these elements to offset the severe constraints (geographic, infrastructural, and financial) of health services in DRC.

SUSTAINABILITY OF SDM IN DRC

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	<ul style="list-style-type: none"> Ensure that the SDM opt-in module is included in the DHS (scheduled for 2013 but now delayed). 	USAID and MOH/DSR
	<ul style="list-style-type: none"> Advocate to UNFPA, WHO, GIZ, PARSS, and Dfid to procure CBs for health zones which they support. 	USAID and MOH/DRH
CAPACITY BUILDING	<ul style="list-style-type: none"> Continue ensuring SDM inclusion in USAID-funded projects. 	USAID
	<ul style="list-style-type: none"> Train and follow up quality of SDM services at the service delivery points in new project/health zones. 	DSR (central trainers)
LOGISTICS AND PROCUREMENT	<ul style="list-style-type: none"> Maintain inclusion of SDM in their product lines in order to ensure procurement and promotion of SDM. 	PSI/social marketing projects
	<ul style="list-style-type: none"> Continue CB orders and supply to USAID-supported health zones. 	USAID/Cycle Technologies
	<ul style="list-style-type: none"> Procure CBs for supported health zones. 	UNFPA, WHO, GIZ, PARSS, and Dfid/Cycle Technologies
IEC	<ul style="list-style-type: none"> Maintain SDM integration in MOH-sanctioned FP IEC materials and media. 	MOH
	<ul style="list-style-type: none"> Include SDM in FP materials and media developed by MOH and new projects sponsored by donors such as USAID, GIZ, UNFPA, Dfid. 	MOH and USAID
HMIS/ MONITORING & EVALUATION	<ul style="list-style-type: none"> Include SDM in 2013/2014 DHS. 	MOH and USAID/MEASURE