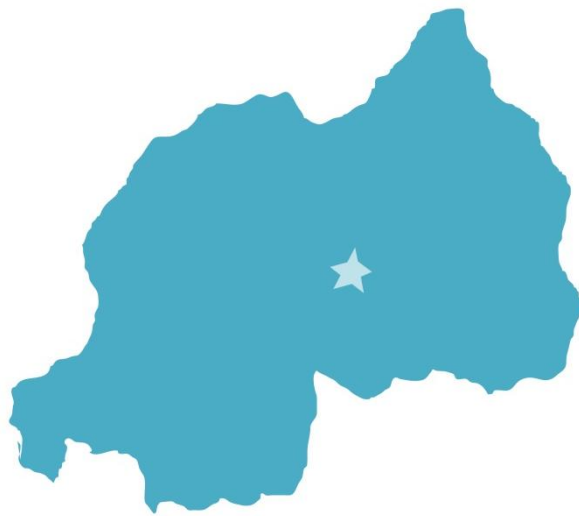


SCALE-UP OF STANDARD DAYS METHOD® IN RWANDA

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, Guatemala, India, Mali, and Rwanda.

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

In 2002, when SDM was introduced in Rwanda, the Ministry of Health (MOH) and its donor partners (especially USAID) supported FP as an important component of the primary health care system's revitalization. The government prioritized population issues—notably, slowing rapid population growth to increase economic and social stability—and backed a strong FP policy and program throughout the country. The sociocultural environment at the time exhibited somewhat contradictory influences: women expressed the desire to plan their pregnancies, yet people felt the need to have large families after the tremendous loss of life in 1994. The 2000 DHS measured unmet need for contraception at 36.4%.

The population of Rwanda is highly religious with up to 40% of health facilities managed or co-managed (with the MOH) by faith-based organizations (FBO). Most of these FBOs support the use of natural FP methods.

The challenge for the MOH and partners was to improve and extend FP services within this unique environment. Expanding the range of available options, and making them more attractive to potential users, was one way to do this. As a natural method with scientific evidence of its effectiveness, SDM had the potential to be a strong addition to the method mix in Rwanda.



Map: Adapted from www.gov.rw

RWANDA AT-A-GLANCE

CURRENT POPULATION:	10.9 million
POPULATION GROWTH RATE:	2.96% per year
GDP PER CAPITA, 2012:	\$582.5
TOTAL FERTILITY RATE:	5.34
CONTRACEPTIVE PREVALENCE, WOMEN AGES 15-49, 2009:	51.6%
UNMET NEED FOR CONTRACEPTION, MARRIED WOMEN AGES 15-49, 2010:	20.8%
MATERNAL MORTALITY RATIO PER 100,000 LIVE BIRTHS:	480
INFANT MORTALITY RATE PER 1,000 LIVE BIRTHS:	38.1

Sources: World Bank World Development Indicators

INTRODUCTORY PHASE 2002-2007

HOW SUCCESSFUL WAS SCALE-UP OF SDM IN RWANDA?

As of December 2012:

SERVICE EXPANSION

SDM services available in 717 service delivery points and in all 30 districts of Rwanda (public, private)

Seven organizations including the MOH are able to build others' capacity to offer SDM

INSTITUTIONALIZATION

SDM fully integrated into national FP program and these sub-systems:

- Most norms, policies, guidelines
- MIS Reporting system
- Pre-service training curricula
- Logistics system
- National surveys
- MOH-sanctioned IEC materials

SDM USERS & KNOWLEDGE OF SDM OPTION

The majority of women (95%) and men (88%) had heard of SDM at endline.

SDM users comprised about 7.4% percent of all FP users. This is an indicator of successful scale-up, based on past IRH studies.

Of those who discontinued SDM, 100% cited their menstrual cycle was outside the eligibility range.

In 2002, USAID invited IRH to provide technical assistance to the MOH to introduce SDM in Rwanda. Using a research-to-practice approach, IRH and the MOH initially selected 13 sites within a USAID-funded health project to pilot SDM services. IRH built MOH capacity to train health workers to provide the method, and supervisors to oversee service quality. By the end of the introductory phase, SDM was available in 74 sites in Rwanda—about 20% of the country—and more than 800 providers were trained to offer the method. Several FBOs and NGOs had gained capacity to deliver SDM services, directly or via their support of MOH health facilities.

Because SDM was introduced while the MOH and donors were revitalizing Rwanda's overall FP program overall, IRH had opportunity to embed the method in policy, protocols and norms as they were being revised. By 2007, SDM was integrated into pre-service and in-service training curricula, the health information system, the logistics system, supervisory tools, national surveys, and information-education-communication (IEC) materials.

IRH research, done at several points during the introductory phase, detected solid evidence of demand for and satisfaction with SDM. More than 90% of users correctly identified their fertile days, and said they and their partners found it easy to manage the 12-day fertile window. Community health workers (CHW) were found to be competent SDM counselors. New SDM users represented five to 12% of all new FP users as early as 2004.

In short, SDM's attributes favored its scale-up in Rwanda: client satisfaction, male involvement, acceptance by churches and users whose religion discouraged the use of hormonal or barrier methods, and ease/appropriateness of service delivery in health facilities and in communities. The MOH, donors and FBOs supported the scale-up phase to increase access and availability, and to further institutionalize the method, in Rwanda.

SCALE-UP PHASE 2007-2012

The *five-year SDM scale-up phase* began in late 2007. In its ongoing role as scale-up catalyst, IRH used the ExpandNet framework to plan its multi-year strategy, to clarify with all stakeholders what successful scale-up meant and what would be required to achieve it, and to maintain appropriate balance along the vertical (institutionalization) and horizontal (geographic expansion) axes of SDM scale-up in Rwanda. During this phase, IRH's Country Representative was an active member of

the MOH's Family Planning Technical Working Group (FP TWG), whose task was to ensure widespread access to a range of FP services and products, including SDM and CycleBeads®, throughout the country.

USING DATA TO GUIDE SCALE-UP

Routine monitoring data, punctuated by several types of evaluation, helped IRH and the FP TWG track SDM scale-up, identify problems and design solutions, detect successes, and inform stakeholders about the contribution of SDM to the national FP program.

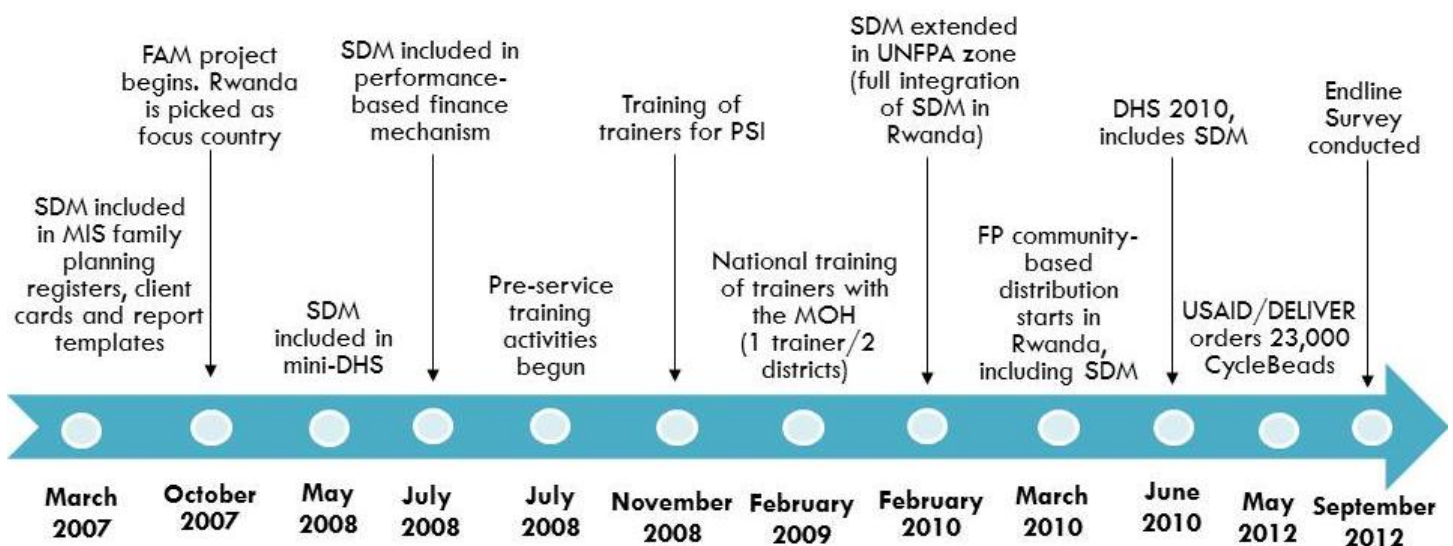
MONITORING DATA: In addition to annual measurement of progress toward benchmark targets (see below), IRH routinely tracked:

- *Service statistics* from health facilities. IRH monitored the number of new FP users by method, detecting SDM's share among the entire method mix and trends over time.
- *Knowledge improvement tool (KIT)* for quality assurance. IRH used this two-page checklist to verify provider knowledge of SDM counseling; after 2010, MOH and FBO partners also used the KIT. Data arising from KIT use helped refine the focus of supportive supervision and the content of refresher trainings.
- *Event timeline.* Tracking key events, and examining them semi-annually, helped IRH and partners detect internal and external influences on SDM scale-up and take appropriate actions.

ATTRIBUTES OF SDM THAT FAVORED ITS SCALE-UP IN RWANDA INCLUDE:

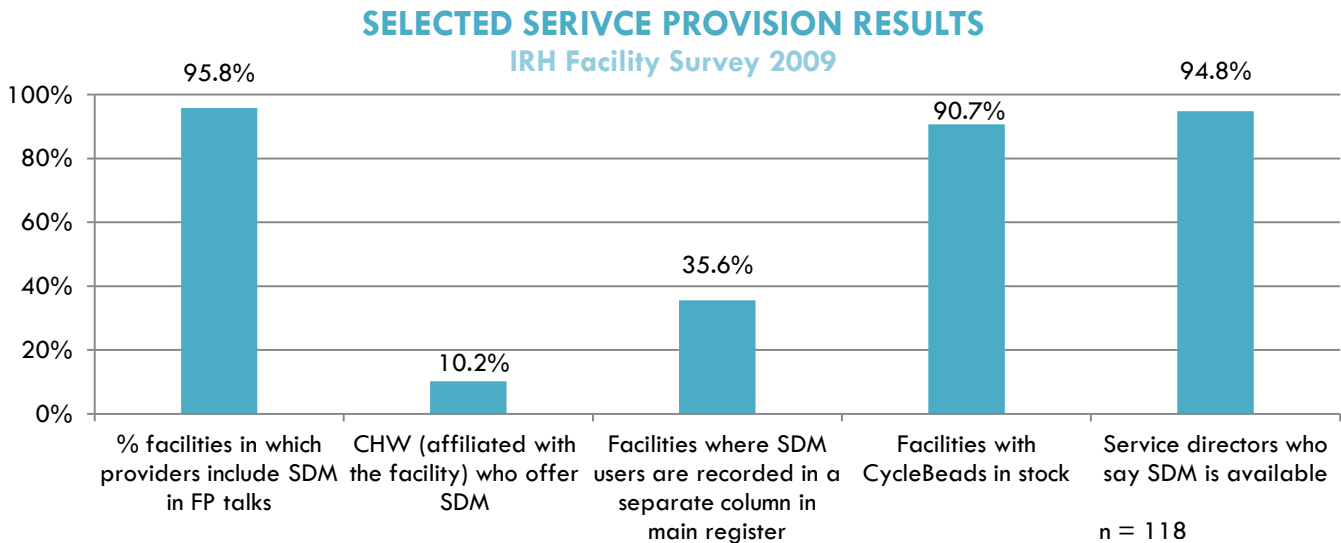
- Client satisfaction
- Male involvement
- Acceptance by churches and users whose religion discouraged the use of hormonal or barrier methods
- Ease and appropriateness of integrating SDM service delivery in health facilities and in communities.

The MOH, donors, and FBOs supported IRH's scale-up phase to increase access and availability, and to further institutionalize the method in Rwanda.



EVALUATION STUDIES: SDM scale-up in Rwanda benefitted from baseline and endline evaluations and additional research:

Baseline Scale-up assessment (2009): This IRH-commissioned study found that 94 percent of facilities visited had at least one provider trained to offer SDM. Among those trained, 87% had offered SDM in the year prior to assessment. Most providers could correctly counsel women how to use CycleBeads. However, a majority of trained providers incorrectly offered SDM to clients who did not know their cycle lengths or told such women to track their cycle before returning to the facility for CycleBeads. This was not consistent with the guidelines, and refresher training was needed to clarify this matter. The assessment found that only eight percent of facilities reported stock-outs of CycleBeads. However, many CycleBeads packages were missing the current calendar, instructions, and/or extra ring.



Stakeholder interviews (2009). A research consultant held in-depth discussions with FP stakeholders in Rwanda. The purpose was to record the insights of representatives of the government, NGOs, FBOs, donors and educational institutes into the political and environmental factors influencing SDM scale up, and their own and their constituents' knowledge of and attitudes towards SDM and FP. Stakeholders recognized SDM's value as part of the national method mix, and the importance of FBOs' acceptance of SDM while the government was revitalizing FP as part of the national development strategy. Interviewees wanted to see stronger promotion of SDM, more service providers trained to offer SDM, and a wider variety of stakeholders advocating for SDM support among political and religious leaders.

ENDLINE ASSESSMENT RESULTS

A structured questionnaire (based largely on the contraception module of the DHS) and to measure SDM knowledge, current and ever use was administered in 2012. The endline was nationally representative and used multi-stage sampling to select 400 women of reproductive age and their male partners. About 95% of the women, and 88% of the men, had heard of SDM.

This compared favorably to knowledge of injection, the most commonly used method in Rwanda. Among women currently using a FP method, 7.4% were using SDM. Of the 400 women surveyed, 21 (5.3%) were currently using SDM and 25 (6.3%) had ever used the method. The four women who abandoned the method did so because their cycles were out of range. All SDM users demonstrated correct use of CycleBeads, and expressed satisfaction and intent to continue use.

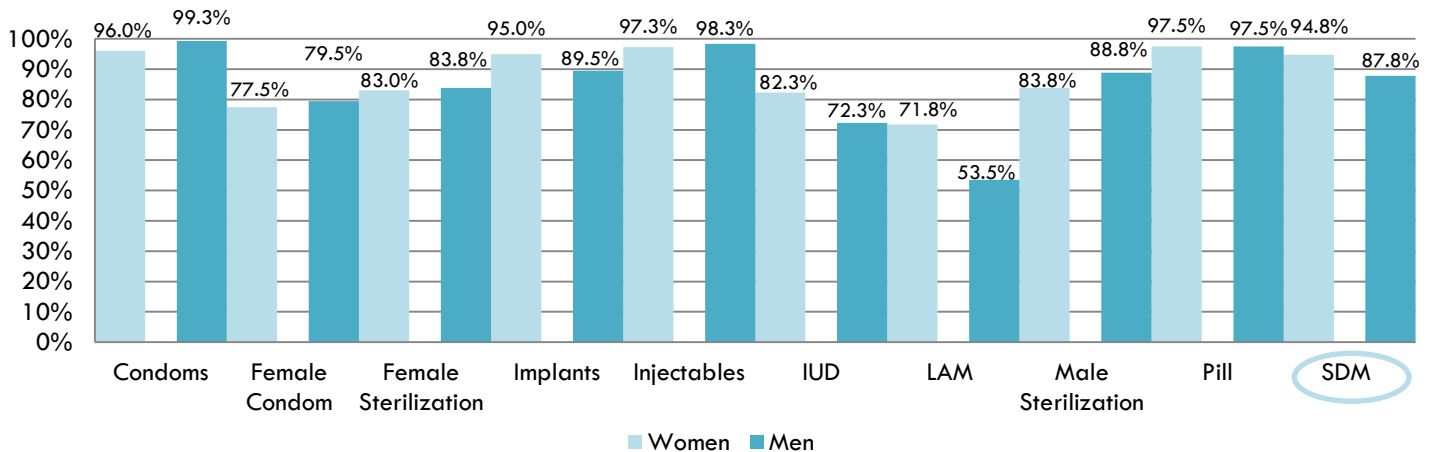
Other components of the endline assessment were:

Community health worker interviews. Of the 73 CHW selected, most were able to counsel correctly, and there were few reports of stock-outs. However, about half of CHW said they asked women to track their cycle or wait for their next menses before providing SDM, creating an unnecessary medical barrier to first time users.

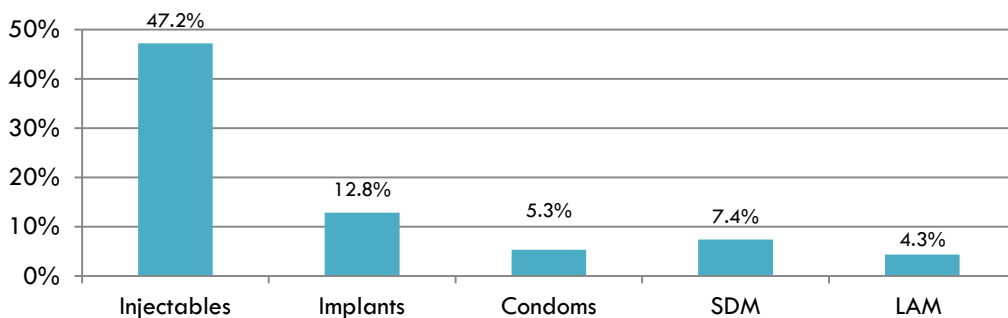
Simulated clients. This methodology detected some provider bias. Ten of 16 simulated clients whose profile suggested they were ideal candidates for SDM reported that they felt pressure to consider other options. Meanwhile, only nine of 16 simulated clients whose profile suggested injection felt they received enough information from service providers to make an informed choice.

Stakeholder interviews. A second round of stakeholder interviews in 2012 found unanimous agreement that SDM was appropriate to Rwanda’s social and cultural environment. All interviewees expressed that the scale-up intervention played a pivotal role in bridging differences between church- and state-managed elements of the health system. All felt that SDM scale-up had been largely achieved, and that little if any provider bias remained. Most pointed to the MOH and FBOs when asked who was responsible for completing the few outstanding scale-up tasks.

PERCENTAGE OF WOMEN AND MEN WHO KNEW OF FAMILY PLANNING METHODS IRH Household Survey 2012



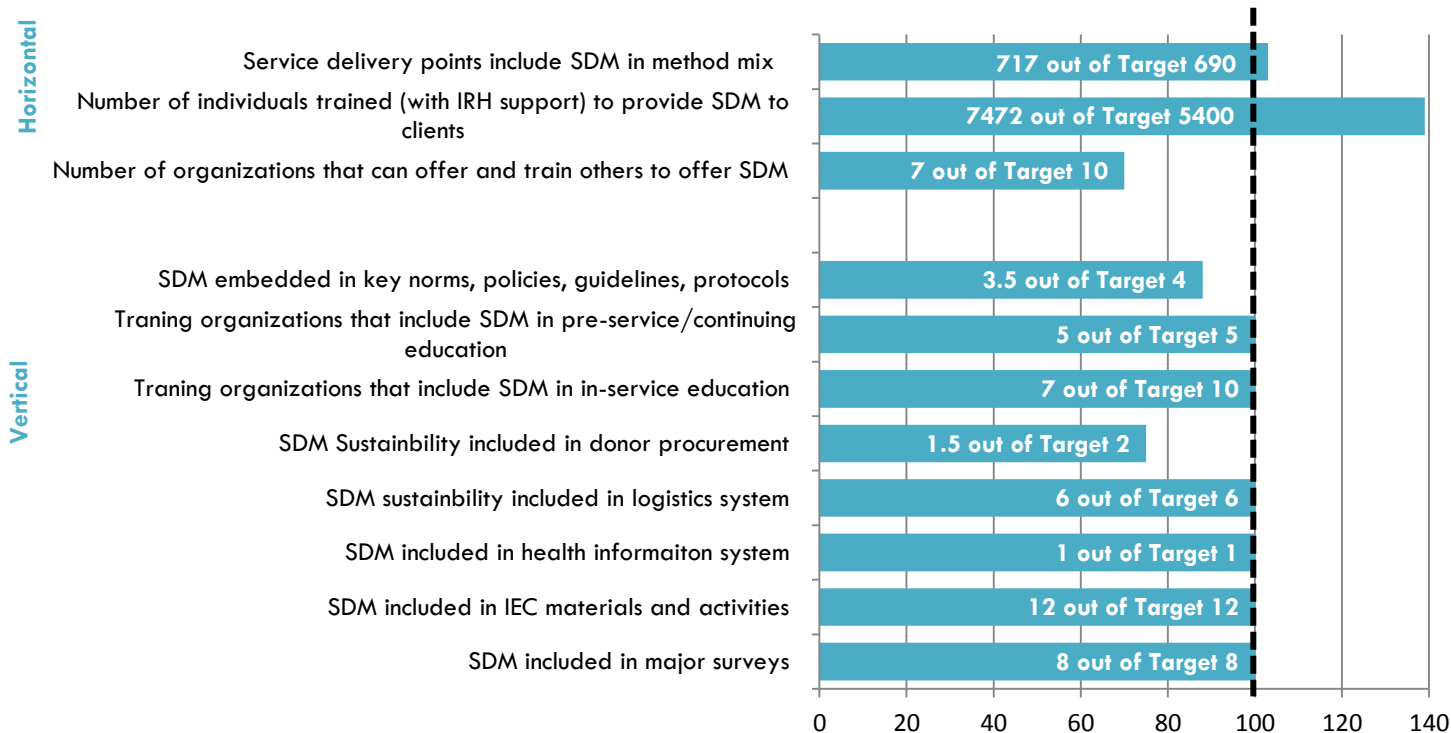
METHOD USE AMONG WOMEN CURRENTLY PRACTICING FAMILY PLANNING IRH Household Survey 2012



ACHIEVEMENT OF SDM BENCHMARK TARGETS

The figure below shows overall strong achievement of benchmarks, both horizontal and vertical, in Rwanda. Each benchmark is then briefly discussed.

PROPORTION OF BENCHMARKS ACHIEVED, RWANDA



IRH's work along the *horizontal* scale increased availability of and provider capacity to offer SDM across Rwanda. By the end of the scale-up phase, 717 service delivery points (103% of target) included SDM in their method mix.

These delivery points—health facilities, outposts,¹pharmacies—were in all 30 of Rwanda's districts.

Work along the horizontal scale increased availability of and provider capacity to offer SDM across Rwanda.

IRH directly supported the training of almost 7,500 individuals to offer SDM. This included both facility- and community-based health workers. The roll out of community-based provision of FP methods including SDM happened very quickly at about mid-point in the scale-up phase, and was a boon to SDM availability in the approximately one-third of Rwandan districts where USAID-funded projects were not supporting health service delivery.

¹ Where church-managed facilities chose not to offer FP methods, the MOH instigated a system of nearby outposts where clients could find the full range of methods including SDM/CycleBeads.

Activities on the vertical scale aimed towards the sustainable institutionalization of SDM in Rwanda.

Seven entities including the MOH gained the capacity to undertake the full range of SDM service provision including training and/or supervising others to offer the method. In ExpandNet terminology, these are resource organizations, and they are important for the sustainability of a health innovation. In addition to the MOH, resource organizations in Rwanda include Caritas and Action Familiale (two key FBOs), ARBEF (the national Planned Parenthood affiliate), and PSI (social marketer).

Activities on the vertical scale aimed towards the sustainable institutionalization of SDM in Rwanda. SDM was integrated into FP policies, norms and protocols, in-service and community health training manuals and supervision tools; in fact,

this was achieved prior to the start of the scale-up phase. By the close of scale-up, however, SDM was not fully integrated into the government's performance-based financing (PBF) system for health services. The method appeared as a unique (and thus countable) item in PBF's 2009 reporting forms, but was dropped in 2010 and following years. Health facilities are financially rewarded only for services they can report; SDM's absence from PBF forms may lead to provider bias against offering the method.

IRH achieved SDM integration into the FP pre-service training curricula before the scale-up phase began. The method was subsequently included in the in-service training provided by seven entities. IRH originally targeted ten entities, but three were donor-funded projects that ended while scale-up was still underway.

FP commodity procurement in Rwanda requires the coordination of several components. First, the FP TWG and another MOH unit meet and review data to determine the type and number of items needed. Second, the Medical Production and Procurement Department orders, tracks, transports and stores the FP commodities. Third, donors USAID and UNFPA commit to pay for the FP commodities. By the end of 2012, SDM was integrated into the first two of these components. In the third, only USAID procured CycleBeads. IRH advocated ceaselessly with UNFPA to procure them, and remained optimistic that it will agree and further sustain the method in Rwanda. The table at right shows the number of CycleBeads procured for Rwanda during the scale-up phase, and what entity purchased them.

CYCLEBEADS PROCURED IN RWANDA, 2007-2012

ORGANIZATION	AMOUNT
USAID	76,100
IRH	4,000
PSI	2,500
Total:	82,600

Source: Cycle Technologies

SDM was included in all of the targeted elements of the logistics system, including requisition and inventory tracking. It was also present in the health reporting system, at facility, district and central levels, by the midpoint of the scale-up phase. The method was included in all IEC materials and media diffused by the MOH and its partners: in this regard, SDM was treated like every other FP method in the national method mix. Finally, the method was included in all important surveys on FP and reproductive health in Rwanda in recent years, including: Demographic and Health Survey (2007, 2010), Barriers to Contraceptive Use Survey and Post-partum Contraception Study (2010, FHI), Service Provision Assessment (INFSS/MACRO, 2007) and others.

SCALE-UP AND THE RWANDA ENVIRONMENT

Most scale-up activity occurred in partnership with the MOH and with USAID-funded health projects.

SDM scale-up in Rwanda benefited from the country's political stability and the government's position that FP was a crucial development tool. That stance, which also held that uncontrolled population growth would prohibit individual and national well-being, steered government policy to promote long-acting and permanent

contraceptive methods. IRH, in response, positioned SDM as a long-term use method, and specifically targeted policy and program decision-makers with this message. Donors, in part to align with MOH priorities, also tended to favor long-acting and permanent methods.

On the other hand, the strong influence of religion on Rwandan life and its health care system created a positive environment for SDM uptake. The scale-up process – notably, SDM’s inclusion in reporting systems - also allowed FBOs to demonstrate their contribution to achieving national FP goals.

Most scale-up activity occurred in partnership with the MOH and with USAID-funded health projects. Two such projects—very large in geographic scale and influence on health services—closed in 2010. Eighteen months passed before USAID awarded a follow-on project; during this gap, key partners were not available to conduct training and supervision and provide general support to the FP program as a whole (and SDM in particular) in about two-thirds of the country.

RESOURCE AND USER ORGANIZATIONS

RESOURCE ORGANIZATIONS IN RWANDA AS OF 2012:

- Action Familiale (AFR)
- ARBEF
- *Central d’Achat de Medicaments Essentiels du Rwanda (CAMERWA)*
- Caritas
- Intrahealth Capacity Project (since closed)
- Intrahealth *Twubakane* Project (since closed)
- Jhpiego MCHIP Bridge Project (since closed)
- JSI Deliver Project
- Kigali Health Institute
- MOH / MCH Division
- MOH / Nursing Division
- PSI

As noted, a resource organization is one that promotes and facilitates wider use of a health innovation—in this case, SDM—while a user organization is one that implements an innovation. In Rwanda, the MOH had the staffing, structure and expertise to serve as the primary resource organization for SDM scale-up. Its Maternal and Child Health Task Force oversaw the scale-up process, while its FP TWG attended to technical tasks such as training trainers and instructors, and resolving CycleBeads distribution to health facilities.

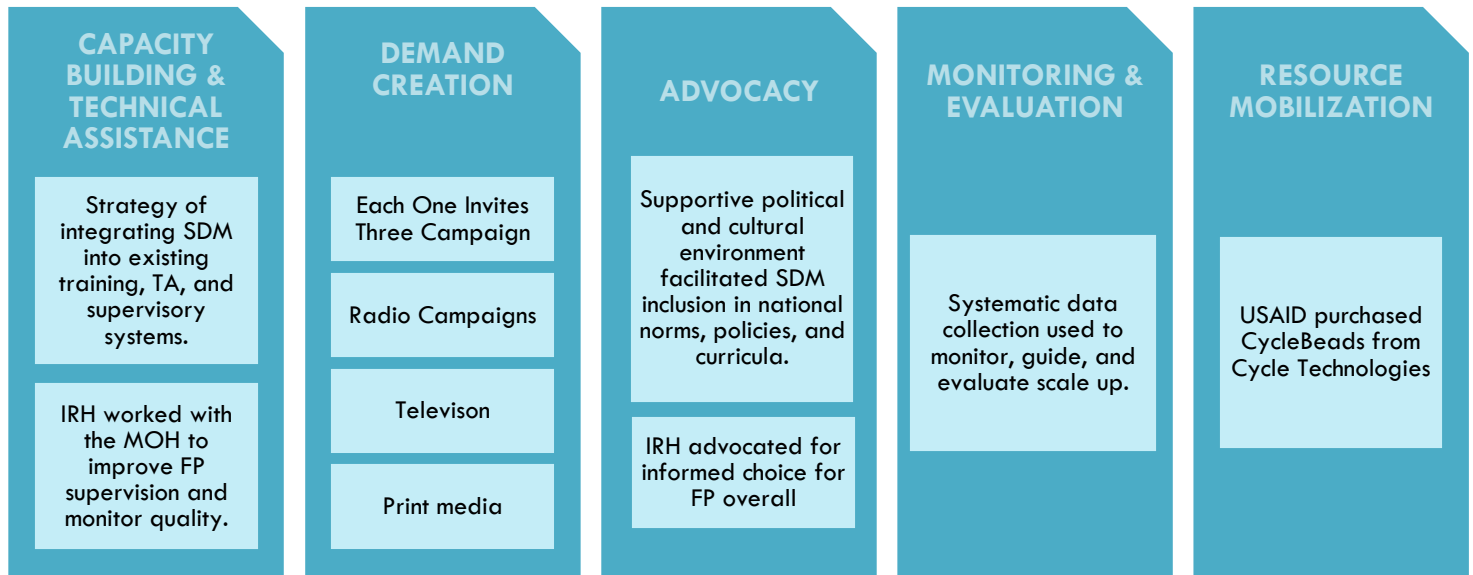


IRH, meanwhile, deliberately chose to play a dual role: as catalyst for scale-up processes, and as resource organization for the MOH and other resource organizations. It participated fully in FP TWG processes, and earned recognition as an innovative, experienced and politically neutral technical assistance agency for FP.

By the end of 2012, entities in Rwanda that qualified as resource organizations included the MOH, two influential FBOs, one NGO, and government bodies with specific roles such as the Kigali Health Institute (health worker training) and the Medical Production and Procurement Department (FP commodity procurement).

STRATEGIC CHOICE AREAS

The ExpandNet framework guided IRH to make strategic choices in several areas based upon a careful analysis of the operating environment in Rwanda. These areas, as they applied to SDM scale-up, are briefly summarized here.



CAPACITY BUILDING AND TECHNICAL ASSISTANCE: One of IRH’s priorities was to build technical capacity within the MOH so it could eventually operate autonomously as a resource organization, respond to SDM needs, and ensure SDM availability well into the future. A key IRH strategy was to integrate SDM training into the training, technical assistance and supervisory systems *already in place* in Rwanda’s public sector. This reinforced those systems, reinforced SDM as an integral part of the method mix, and reinforced the competencies of existing MOH trainer-supervisors at central and district levels. Among notable training activities:

- The constant mobility of MOH health workers meant that refresher trainings were essential, and IRH spearheaded a series of them around the country.

During the Each One Invites Three campaign, satisfied family planning users distributed written invitations to non-user friends to visit the nearest facility or CHW to learn about contraception. Several districts saw a nearly 50% increase in new family users.

- Health services in 23 of Rwanda’s districts were supported by USAID projects, and the remaining seven were nominally supported by UNFPA. Yet that organization had no projects on the ground during the SDM scale-up phase. In these districts, IRH and the MOH trained MOH trainers in FP (including SDM), and these individuals subsequently trained providers in a cascade approach.
- Leading FBOs learned to provide trainings to church-managed health facilities, in some cases using materials IRH revised to exclude mention of condom use during the fertile period.
- When the MOH piloted community-based provision of selected FP methods, IRH offered its global CHW toolkit as a guide for curriculum development. IRH contributed to training plans, and seconded its training officer to the training of trainers.

In the realm of quality assurance, IRH worked with the MOH to improve supportive FP supervision, with a particular interest in reversing the slight provider bias against SDM that was detected in several surveys. IRH used the KIT, as both a measurement and training tool, with the MOH and other user organizations, including FBOs. Data collected via the KIT in 2010 showed that service providers were performing quite well overall, but about 40% still had difficulty determining a client's eligibility to use SDM. To expand SDM coverage to the last seven districts in Rwanda, IRH and MOH established a system of Focal Points: district MOH staff who, during regular FP supervision, paid particular attention to SDM. They used the KIT to improve provider skills and knowledge of the method, and counteract any provider bias that arose.

In 2007, the Ministries of Health and Education created a unified nursing curriculum. The revised curriculum began with fertility awareness and the menstrual cycle, and then moved logically to SDM as the first FP method presented to students.

Much of SDM integration into service provider training curricula took place prior to the scale-up phase. However, in 2007 the MOH and the Ministry of Education reorganized nursing schools and unified the nursing curriculum. IRH participated in the revision of the reproductive health segment and subsequent training of professors. Of note, the revised curriculum began with fertility awareness and the menstrual cycle, then moved logically to SDM as the *first* FP method presented to students.

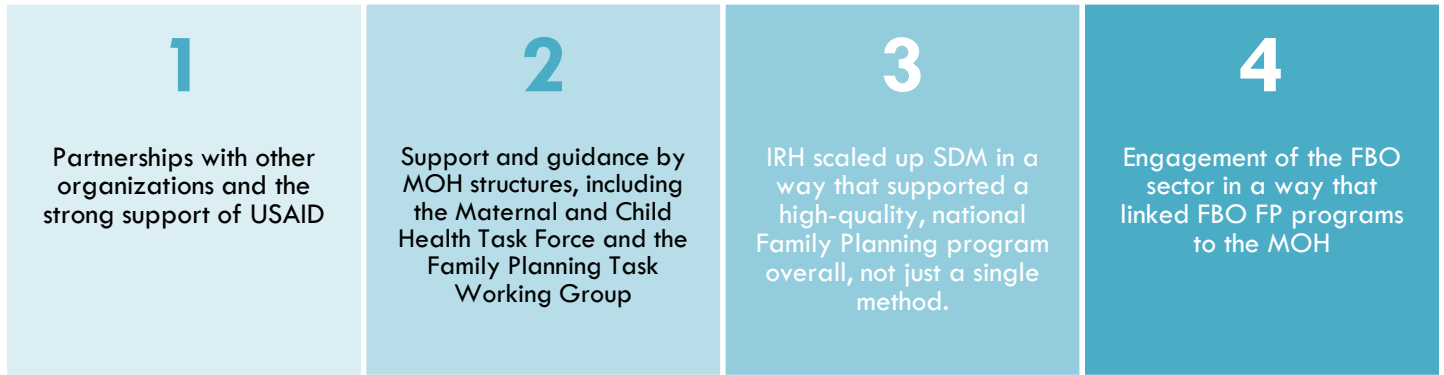
DEMAND CREATION: IRH worked with several partners, including but not limited to members of the FP TWG, to raise awareness of and create demand for SDM, via channels such as radio, television and print media. Determined to go beyond these useful but standard approaches, IRH led and supported MOH and community-based organizations (women's and men's groups, and CHWs) to conduct an interpersonal communication campaign called *Each One Invites Three*, in which satisfied FP users distributed written invitations to non-user friends to visit the nearest facility or CHW to learn about contraception. The six-month campaign was largely successful – several districts saw a 39% increase in new users—and the MOH asked all FP partners to implement the campaign in their project areas.

ADVOCACY: SDM scale-up benefitted from a positive and supportive political and even cultural environment in Rwanda. The method was readily included in national norms, policies and curricula. Still, IRH continued to advocate throughout the scale-up phase, and in fact was an advocate not only of SDM but of informed choice for FP overall. Its stance was that SDM scale-up was an end in itself, but also a means by which the national FP program as a whole could be improved.

MONITORING AND EVALUATION: The systematic M&E plan has been outlined in the earlier section. Many different data sources were used to collect data to monitor scale-up processes and to evaluate outcomes.

RESOURCE MOBILIZATION USAID ended its field support funding to IRH in 2009, but continues to work with Cycle Technologies to procure CycleBeads for local organizations in Rwanda.

KEY ELEMENTS THAT FACILITATED SCALE-UP IN RWANDA



In addition to the positive political environment in which scale-up occurred, IRH noted several elements that favored SDM’s institutionalization and expansion in Rwanda:

- IRH is a small organization that operated through partnerships to amplify the effects of its work, and USAID’s strong support was very useful in cementing these partnerships. USAID commented publicly and privately about IRH’s technical and diplomatic skills, and the value of partnering with IRH.
- Likewise, MOH structures—notably, the Maternal and Child Health Task Force and the FP TWG—were able to witness the SDM scale-up process as one that contributed to FP revitalization as a whole. As scale-up progressed, IRH research was instrumental in eliciting commitment from task force and working group members. For example, when one study detected gaps in CycleBeads availability, a TWG partner took action to address the problem.
- IRH scaled up SDM in a way that supported a high-quality, national FP program overall, and not merely a single method within it. In 2010, the MOH asked IRH to build FP capacity at the district level—evidence that the institute had succeeded in positioning itself as an FP (and not only an SDM) advocate.
- The engagement of the FBO sector, particularly Caritas and its network of health facilities, allowed access to almost 40% of health facilities for SDM integration and also allowed creation of a sustainable relationship in FP programming between the MOH and Caritas.

SUSTAINABILITY OF SDM IN RWANDA

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"> Advocate for re-insertion of SDM into the PBF system. 	USAID, MOH MCH Task Force and Community Health Desk, and MSH
	<ul style="list-style-type: none"> Lobby PSI (once it transitions to a Rwandan social marketing NGO) to include CB in their product line. 	USAID
	<ul style="list-style-type: none"> Advocate for Catholic FBOs providing SDM services outside of health facilities (e.g. Action Familiale) to have access to CB. 	USAID and MCH Task Force
	<ul style="list-style-type: none"> Advocate to FBOs to report their FP statistics to district MOH. 	MOH FP Technical Working Group
CAPACITY BUILDING	<ul style="list-style-type: none"> Maintain SDM in national FP training materials and activities for facility and community level providers of FP. 	MOH FP Technical Working Group
	<ul style="list-style-type: none"> Ensure SDM is part of FP activities in new bilateral projects (e.g. Chemonics Project Family Health Project). Existing staff have capacity already. 	USAID
LOGISTICS AND PROCUREMENT	<ul style="list-style-type: none"> Continue CB procurement for the public sector. 	USAID/Cycle Technologies
	<ul style="list-style-type: none"> Procure and supply CBs for use in private sector social marketing, including funding for promotion 	USAID/Cycle Technologies
	<ul style="list-style-type: none"> Continue including CB in their product line. 	PSI
	<ul style="list-style-type: none"> Access MOH condoms and replace inserts that include condom language with their own. 	FBOs
IEC	<ul style="list-style-type: none"> Monitor SDM inclusion in new FP materials are developed by the MOH or FP projects. 	MOH FP Task Force
HMIS/ MONITORING & EVALUATION	<ul style="list-style-type: none"> Systematically report FP statistics to district MOH to include in FP user statistics. 	Caritas & Action Familiale