

Scaling Up From the Start: Beginning with the End in Mind
International Conference on Family Planning, Kampala, Uganda: November 18, 2009

Workshop organizers: Family Health International, Institute for Reproductive Health at Georgetown University, ExpandNet/WHO

Disclaimer: This case is intended solely for educational purposes to illustrate key concepts regarding scale up. All information in this case — including characters, scenarios, and data — is fictitious and does not relate to actual people or programs. Information presented below regarding health service delivery models and costs should not be used for program planning or research purposes.

Background on the Standard Days Method

The Standard Days Method (SDM) is a modern method of family planning that is based on probabilities of ovulation during women's menstrual cycles and women's awareness of when they are likely to become pregnant. The SDM is most often practiced with CycleBeads, a color-coded set of beads that allows women and couples to track monthly menstrual cycles. On the 'white bead' days (days 8 through 19 of a woman's cycle), the woman is likely to become pregnant if she has unprotected sex. To use this family planning method, the couple either abstains or uses condoms on white bead days.

The Institute for Reproductive Health (IRH) at Georgetown University developed and tested the SDM in the late 1990s/early 2000s – first developing a theoretical model, then conducting efficacy studies in three countries that showed that the method is 95% effective when used correctly, followed by a series of operations research studies to learn the feasibility of adding the SDM into family planning services in demonstration settings – from the provider, user, and health systems perspectives. WHO, UNFPA, USAID, and other normative agencies now acknowledge the SDM as a modern family planning method. From the early 2000s to present, IRH has worked with Ministries of Health, NGOs, and private sector entities to introduce the SDM in over 40 countries.

Through the Fertility Awareness-based Methods (FAM) Project, the SDM is being taken to scale in five countries, including DRC, Guatemala, India, Mali, and Rwanda. An important activity of the FAM Project is to study scale up of the SDM, to identify factors that enhance and inhibit scale up processes and outcomes.

Exercise 1: Designing a pilot intervention

An international organization, Healthy Families International (HFI), has donor funding to introduce the SDM into health services in the West African country of Malidougou. While the SDM was recently included in MOH family planning policies, the method and CycleBeads are not yet available in country. HFI has held several meetings with key stakeholders, including the MOH, UNFPA, USAID-funded projects, and several international

NGOs operating in Maldougou to solicit input into the design of the pilot project. The MOH would like HFI to introduce the SDM into the public sector—at both the clinic and community level—because they are very enthusiastic about its potential to bring new users to family planning and help address unmet need. They intend to incorporate SDM into their 10-year FP/RH strategic plan, which they are currently developing and would like it to be available at a national scale as soon as possible. However, HFI has decided to introduce the SDM in five private clinics affiliated with an international NGO, Women’s Health and Development (WHD), because they feel it has the best infrastructure, the highest caliber providers and the most resources to put toward purchasing CycleBeads and funding IEC efforts. The pilot project will last six months. If the introduction in the WHD private clinics is successful, HFI intends to work with the MOH to build their capacity to begin scaling-up the SDM in the national public health sector, thereby reaching millions of women.

Case study questions

- *What in this plan is problematic? Is there a better way to design the pilot activity?*
- *What questions should we ask HFI to determine whether this pilot is designed to maximize potential for scale up?*

Exercise 2: Implementing a pilot study/demonstration

As part of the pilot project, HFI will be researching various aspects of SDM service delivery, including provider competency and attitudes, and client satisfaction. In addition, the MOH requested that HFI and WHD document the cost of the introducing the SDM in the five private clinics. The MOH will use this information to project how much it will cost to scale-up the SDM nationally in the public sector.

Introducing the SDM included several activities, noted below, along with their corresponding costs. HFI hired a consultant to guide many of these activities. Review the expenses represented below.

Financial Costs: Introducing SDM into 5 private clinics		
Activity	Resource (Expense Item)	Amount (in US dollars)
Meeting with policymakers at the Ministry of Health to introduce the SDM and obtain official approval for the pilot	Venue fee plus consultant/facilitator fee	\$500
Adaptation of existing training and IEC materials	Consultant time	\$3,000
One-day training for clinic providers and supervisors	Consultant time + venue fee+ materials+ supplies+ CycleBeads	\$1,950
Printing provider job aids and client brochures	Printing costs	\$500
Developing and airing radio spots about the availability of SDM	Consultant time and radio station fees	\$780
Travel for consultant (for above activities)	Airfare, hotel, per diem	\$8,000
Purchasing 500 CycleBeads for service delivery	Cost of CycleBeads from manufacturer	\$500
Support-Malidougou supervisor for pilot project	Supervisor’s salary	12,000
Allocated administrative overhead for 5 Support-Malidougou clinics	% of administrative costs for 5 clinics	5200
	Total financial costs	\$32,430

Case study questions

- *Has anything been left out? Is anything included which should not be included?*
- *How will this information be used by policymakers to make decisions regarding SDM scale-up?*

Exercise 3: Scaling-up after a pilot study

After the pilot was successfully completed, HFI and WHD decided to organize a meeting to discuss the findings and begin to plan for scale up. The MOH/Division of Reproductive Health was a bit surprised, since they had not heard from HFI in over 18 months (since they began their pilot activities). After much discussion, the MOH/DRH agreed to co-host a FP stakeholder's meeting to discuss the findings of the SDM introduction activities. Given the encouraging results – providers liked the SDM and offered it competently and new FP clients were interested in using the method in the five private clinics – the group decided to do a second demonstration activity, adding the SDM into MOH health facility services in one district. The stakeholders also decided to delay adding the SDM into community-based services until there was more evidence from public sector settings. At the meeting, the MOH and other stakeholders developed a multi-year, multi-organization plan to guide this and subsequent efforts.

After six months of introducing the SDM into family planning service delivery in the pilot district, HFI and MOH supervisors conducted follow up visits to a sample of the public-sector sites and found several issues in the quality of service delivery. Even though providers left the SDM training session with knowledge and skills in offering the new method, when providers returned to their sites, many began to deviate from what they learned. Apparently, thinking it was a 'couple's method,' providers in about one-quarter of the sites would only counsel couples on the SDM, and not the woman alone. This compromised women's reproductive rights, created an unnecessary medial barrier, and was against Ministry policy. Some issues were also found with explaining how to use the method to new users.

In addition, an important shift in the political environment had occurred the month prior to the follow up visits to the pilot sites. The head of the Division of Reproductive Health in the central ministry was replaced and two District Medical Officers who were championing SDM roll out in their districts were transferred.

Case study questions

- *Assuring the quality of offering a new FP method is going to be an issue when taking it to scale. What strategies could the MOH and HFI use to support quality assurance while scaling up the SDM? Which MOH systems (eg, HMIS, training systems) influence quality assurance of offering the SDM? What could be done differently in designing the scaling up process to avoid quality assurance problems?*
- *What comments do you have about changing political environments during a multi-year scale up process? What strategies could HFI and its counterpart organizations use to manage changing political environments, such as the one noted, above?*

FACILITATOR NOTES:

Exercise 1:

Case study questions:

- *What in this plan is problematic? Is there a better way to design the pilot activity?*
- *What questions should we ask HFI to determine whether this pilot is designed to maximize potential for scale up?*

- *Probing questions for small group facilitators:*
- *Is the organization that will pilot the innovative intervention the same as the organization that is expected to adopt it on a large scale if successful? If not, why not?*
- *Will pilot testing take place in the routine type of setting where the intervention is expected to be implemented as it goes to scale? (For example, if the pilot takes place in the national health system, were sites with average capacity chosen or sites which are special in terms of location, motivation of personnel, facilities and other resources?)*

-
-
- *Exercise 2:*

Case study questions

- *Has anything been left out? Is anything included which should not be included?*
- *How will this information be used by policymakers to make decisions regarding SDM scale-up?*

- *Probing questions for small group facilitators:*
- *What costs might be greater at scale? What costs might be less?*

-
-
- *Exercise 3:*

Case study questions

- *Assuring the quality of offering a new FP method is going to be an issue when taking it to scale. What strategies could the MOH and HFI use to support quality assurance while scaling up the SDM? Which MOH systems (eg, HMIS, training systems) influence quality assurance of offering the SDM? What could be done differently in designing the scaling up process to avoid quality assurance problems?*

- *What comments do you have about changing political environments during a multi-year scale up process? What strategies could HFI and its counterpart organizations use to manage changing political environments, such as the one noted, above?*