

# Scale-Up of the Standard Days Method® (SDM) in India

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The Institute for Reproductive Health  
Georgetown University



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The Institute for Reproductive Health (IRH) is part of the Georgetown University Medical Center, an internationally recognized academic medical center with a three-part mission of research, teaching and patient care. IRH is a leading technical resource and learning center committed to developing and increasing the availability of effective, easy-to-use, fertility awareness-based methods (FAM) of family planning.

IRH was awarded the 5-year Fertility Awareness-based Methods (FAM) Project by the United States Agency for International Development (USAID) in October 2013. This 5-year project aims to increase access and use of FAM within a broad range of service delivery programs using systems-oriented scaling up approaches.

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## Acronyms

<b>ACMO</b>	Assistant Chief Medical Officer
<b>ANM</b>	Auxiliary Nurse Midwife
<b>CFU</b>	Client Follow Up
<b>CHW</b>	Community Health Worker; in Jharkhand state, these are called <i>sahiyyas</i>
<b>CPR</b>	Contraceptive Prevalence Rate
<b>CTU</b>	Contraceptive Technology Update
<b>DSW</b>	Department of Social Welfare
<b>FP</b>	Family Planning
<b>GOI</b>	Government of India
<b>HTSP</b>	Healthy Timing and Spacing of Pregnancies
<b>LAM</b>	Lactational Amenorrhea Method
<b>IEC</b>	Information, Education, Communication
<b>IPC</b>	Interpersonal Communications / Communicator
<b>IRH</b>	Institute for Reproductive Health, Georgetown University
<b>KGVK</b>	Krishi Gram Vikas Kendra, an NGO based in Jharkhand
<b>KIT</b>	Knowledge Improvement Tool
<b>LHV</b>	Lady Health Volunteer
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MO</b>	Medical Officer
<b>MOH</b>	Ministry of Health
<b>MOHFW</b>	Ministry of Health and Family Welfare
<b>MPW</b>	Multi-purpose Health Worker
<b>MSC</b>	Most Significant Change
<b>NFHS</b>	National Family Health Survey
<b>NRHM</b>	National Rural Health Mission
<b>PSI</b>	Population Services International
<b>RH</b>	Reproductive Health
<b>SDM</b>	Standard Days Method
<b>SDP</b>	Service Delivery Point
<b>TA</b>	Technical Assistance
<b>TFR</b>	Total Fertility Rate
<b>UNFPA</b>	United Nations Population Fund

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## Executive Summary

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 Democratic Republic of Congo, Guatemala, India, Mali, and Rwanda. This report summarizes events in the state of Jharkhand in India, including choices, approaches and results of systematic SDM scale-up and related research. It concludes with an analysis of factors that influenced scale-up.

India's national *FP program* was launched in 1951, and was the *world's first governmental population stabilization program*. For many decades, the FP program emphasis was on sterilization, resulting in limited adoption of reversible methods and information about the benefits of birth spacing. However, following the 1994 International Conference on Population and Development (ICPD), which recommended high-quality services and a range of methods, the Government of India (GOI) also adopted a target-free approach to FP within the framework of informed choice, making client centered approaches the mainstay of their program. IRH's work to expand access to SDM in Jharkhand reflects the state of Jharkhand's desire to improve FP services and options for its citizens.

The state of Jharkhand is home to 33 million people, larger than all but 30 nations in the world. Most of whom live in rural areas and have low education and literacy rates. A new state in the Indian union, Jharkhand was created in 2000 from the southern portion of the state of Bihar. Although the Government of Jharkhand inherited a weak public health system, there were no entrenched policies and the new state was willing to adopt innovative strategies to tackle health challenges.

Jharkhand's reproductive health (RH) situation was poor. Early childbearing and closely spaced births contributed to high infant and maternal mortality. The total fertility rate was among the



Map: [www.indiabook.com](http://www.indiabook.com)

## JHARKHAND AT-A-GLANCE

**CURRENT POPULATION:** 33 million

**CHARACTERISTICS OF POPULATION:**  
76% rural; low education and literacy; 60.2% married before age 18

**TOTAL FERTILITY RATE:** 3.2

**CONTRACEPTIVE PREVALENCE RATE:** 35.7%  
(vs. 56% in all of India)

**UNMET NEED FOR CONTRACEPTION MARRIED WOMEN AGES 15-49, 2006:** 3.1%

Sources: Census of India 2011, India DHS 2005-2006, Sample Registration System, 2009

highest in India (3.2, SRS, 2009) and contraceptive use was low—about 36% in 2006 and mostly due to female sterilization. Use of IUDs, pills and condoms was particularly low. The Government of Jharkhand saw the potential for culturally acceptable methods such as SDM that could help women delay and space births.

## Introductory Phase 2001 - 2007

IRH had worked in India before it introduced and subsequently scaled up SDM delivery in Jharkhand. After a multi-country study established the efficacy of SDM, USAID funded IRH and several Indian organizations to assess the feasibility of introducing SDM in India. From 2001-2004, IRH conducted two operations research studies to test the feasibility of offering SDM in community-based RH programs. One was in rural Uttar Pradesh (with CARE in Sitapur district), the other in Delhi slums (with Community Aid and Sponsorship Program and CEDPA). Results of these studies indicated that in both rural and urban areas there was a demand for SDM, users were highly satisfied with the method, women liked the lack of side effects and health risks, the method could be easily taught by providers and community health workers (CHW) and correctly used by women and their partners.

### RESULTS OF SDM INTRODUCTION STUDY IN RANCHI, JHARKHAND 2004-2007

- 30% of new FP users chose SDM
- 88% of SDM users had never used FP, suggesting that SDM attracts first-time users
- Simulated client results showed that MOHFW providers, Anganwadi workers, and CHWs all provided high-quality SDM services
- Community-level workers were key to expanding access
- Introducing SDM improved FP counseling overall- especially for condoms

These results attracted the interest of the GOI Ministry of Health and Family Welfare (MOHFW) and led to integration of SDM into several national-level documents. In 2005, the GOI included SDM in its Reproductive and Child Health--Phase Two Program Implementation Plan, and UNFPA and the GOI included SDM in their Contraceptive Update Manual for medical officers. Interest in SDM within India continued to grow, and IRH began to work with a wider range of partners to integrate SDM into the FP initiatives of various NGOs. The MOHFW of the State of Jharkhand also became interested in SDM as a result of the successful introduction studies.

In 2004, the Jharkhand MOHFW, IRH, and other partners including CEDPA and Krishi Gram Vikas Kendra—a Jharkhand-based health and development NGO—jointly designed a USAID-funded introduction study that would test the integration of SDM into the state’s RH/FP and child health services program. The study introduced SDM in public health services in two blocks of Ranchi district with a population of about 200,000; a third block served as a control. This was the first time SDM was offered by public sector health services in India.

The study results offered compelling evidence to the Jharkhand MOHFW that SDM was appealing to women and men and feasible to offer in the public sector by all levels of providers. Results of the introductory phase were disseminated at meetings where the Jharkhand MOHFW officials publicly stated their desire to scale-up SDM. The testimony of SDM providers and users from Jharkhand provided additional support to this decision.

## Scale-Up Phase 2007 - 2013

### HOW SUCCESSFUL WAS SCALE-UP OF SDM IN JHARKHAND, INDIA?

As of May 2013:

#### SERVICE EXPANSION

SDM services are available in 1900 service delivery points in the state of Jharkhand.

Four organizations are able to build others' capacity to offer SDM

#### INSTITUTIONALIZATION

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

- Norms, policies, guidelines
- in-service training curricula
- Logistics system
- Health Information reporting system

#### SDM USERS & KNOWLEDGE OF SDM OPTION

49.1% of women and 41.8% of men in Jharkhand heard of SDM at endline.

Among women using FP at endline, about 6% were using SDM.

The Jharkhand MOHFW wanted a step-by-step scale-up process, with technical assistance from IRH beginning in three districts and adding two to three more districts per year. Under this plan, half of Jharkhand's 24 districts would be fully covered at the end of a five-year scale-up period. The MOHFW selected Gumla, Deoghar, and Chatra as the first three districts because of their low CPR. In October 2007, the MOHFW issued formal notification letters to the three districts, thereby officially commencing the SDM scale-up phase and the IRH-MOHFW affiliation. These letters permitted IRH to begin orientation meetings and conduct master trainings in the three districts. The scale-up partnership was solidified in October 2008 when the MOHFW officials signed a Memorandum of Understanding with IRH to commit approximately US \$200,000 to be invested in government scale-up activities, including trainings, communication materials, and CycleBeads® procurement.

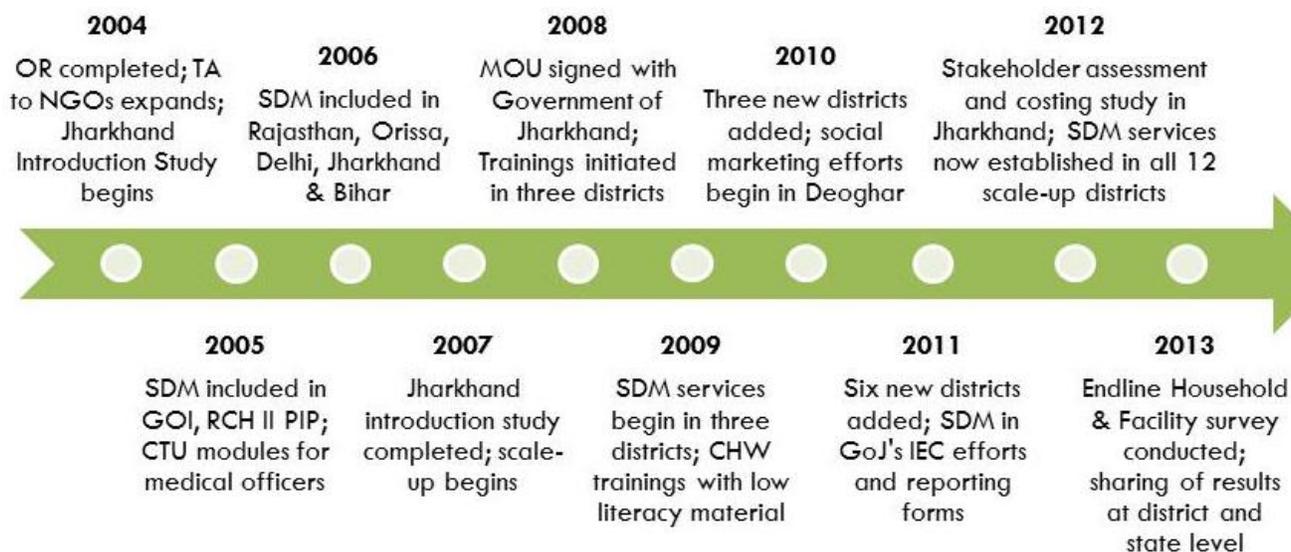
IRH adopted the World Health Organization's ExpandNet framework for scaling up SDM in Jharkhand. This framework guides the scale-up process, its components and goals, and the technical assistance needed to achieve those goals. Through participatory meetings that brought together ExpandNet experts from WHO with IRH, USAID/India and Jharkhand's MOHFW stakeholders, initial planning was strategic and systematic. Goals, benchmarks and subsequent activities focused on both *horizontal* scale-up—the geographic expansion of SDM through availability of information, trained providers and CycleBeads—and *vertical* scale-up—

SDM scale-up in India was guided by principles of systems thinking, sustainability, scalability, and respect for equity, as articulated by the ExpandNet framework.

institutionalization of SDM in all state systems required for maintaining sustainable, quality services. These include policies, budgets, procurement, logistics, health information systems, monitoring and evaluation, training curricula and ongoing demand creation activities.

SDM integration was not narrowly defined. It was geared towards strengthening the FP program in general and provision of SDM and LAM services in particular so that the MOH/FW system would be better equipped to provide a full range of birth spacing methods and high-quality counseling thus maintaining the principle of informed choice for clients. SDM scale-up in India was guided by

principles of *systems thinking, sustainability, scalability, and respect for equity*, as articulated by the ExpandNet framework. Scalability was a key concern and led to streamlining and simplifying SDM provider training and client materials to make SDM scale-up easier. To advance equity, gender issues were addressed in counseling and IEC, and scale-up focused on reaching the most underserved and isolated segments of the population. IRH advocated with MOHFW officials throughout the scale-up phase to ensure their continued support.

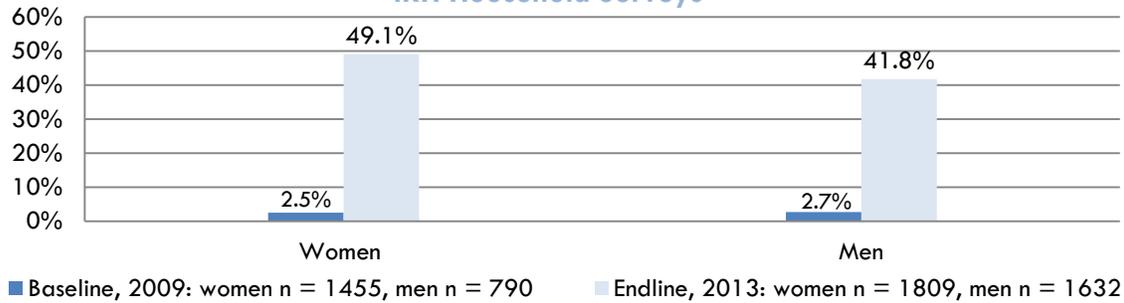


## Using Data to Guide Scale-Up

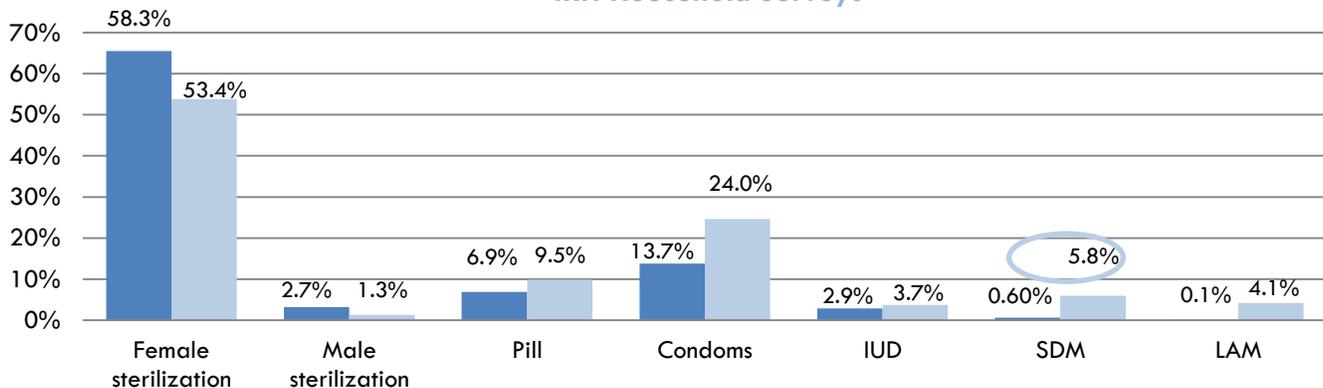
A variety of data, both quantitative and qualitative, was regularly collected to monitor scale-up, make midcourse corrections, and evaluate results. Documenting the scale-up process helped identify gaps and take corrective action. It provided evidence on successes to replicate and failures to avoid. For example, the midline service delivery point (SDP) survey found that there were stock-outs of FP commodities (defined as absence of commodities in the last three months): in 24% of SDPs CycleBeads were unavailable and in 26% condoms were unavailable. By the time of the endline survey, IRH and the Jharkhand MOHFW had succeeded in reducing stock-outs, and only 7% of facilities lacked CycleBeads and 9% lacked condoms. Similarly, inadequacies observed in SDM counseling led to reinforcements on site which improved the performance of providers. Ongoing quality improvements led to a shift of attitudes among representatives of stakeholders. Initially skeptical about the feasibility of SDM training at the baseline interviews, by the endline interviews these stakeholders had fully endorsed further training.

**Awareness and Use:** Awareness of SDM among women increased from 2.5% at baseline to 49.1% at endline household surveys; a similar increase, from 2.7% to 41.8%, was also found among men. Among women practicing FP, the percent using SDM increased from 0.6% at baseline to 6.0% at endline. It was also important to ensure that clients who had chosen SDM were using it correctly. Through client follow-up, IRH determined that in most areas, 80 to 90 percent of clients were using the method correctly.

## AWARENESS OF SDM IRH Household Surveys



## METHOD USE AMONG WOMEN CURRENTLY PRACTICING FAMILY PLANNING IRH Household Surveys



Injectables, implants, diaphragm, foam/jelly, and female condom were each less than 1% at both baseline and endline. Rhythm, withdrawal, and other traditional methods not shown.

**Service Provider Capacity and Method Availability:** SDM knowledge and skill among service providers were measured through systematic use of a competency checklist during ongoing program supervision and endline facility assessments. Endline surveys with providers found that 98% were aware of SDM and 87% had offered it in the last year. Assessments of over 2500 providers during regular supervision found that the mean score for knowledge about how CycleBeads work was 84% and their ability to screen for cycle length criterion for the method was 88.7% combined for physicians, nurses, ANMs and community workers. Recording of SDM users was reported by 67% of service providers interviewed during the endline survey. The chart below shows selected results on service provision in 2010 and 2013.

### Achievement of SDM Scale-Up Benchmark Targets

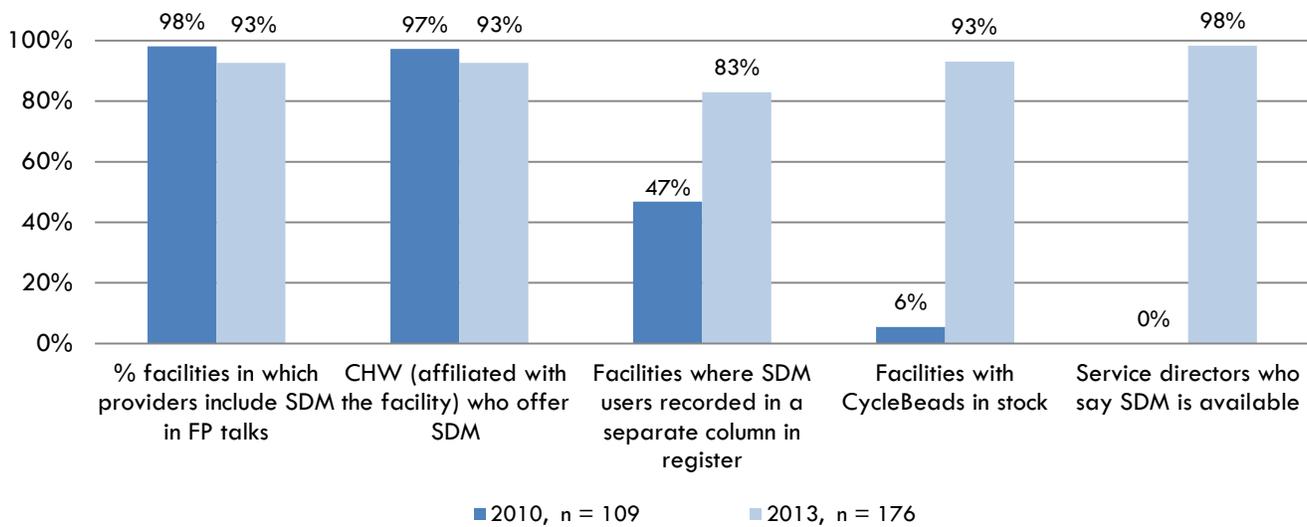
The table below presents the substantial endline achievements in SDM scale-up as a proportion of the benchmark targets that IRH and the MOHFW set for Jharkhand, for both horizontal (geographic) and vertical (institutionalization) scale-up. The Jharkhand MOHFW and IRH were able to expand SDM availability to half of the 24 districts of Jharkhand, an area of approximately 12 million people, where it is now offered in 1900 of the 2100 SDPs that were projected to be operating by the endline. While this figure represents 90% of the benchmark target, it should be noted that two of the districts selected for scale-up in the third phase (2010) were smaller districts and therefore the

number of SDPs and providers were lesser than projections made in 2007- 2008. So the success rate could be considered to be higher than 90%.

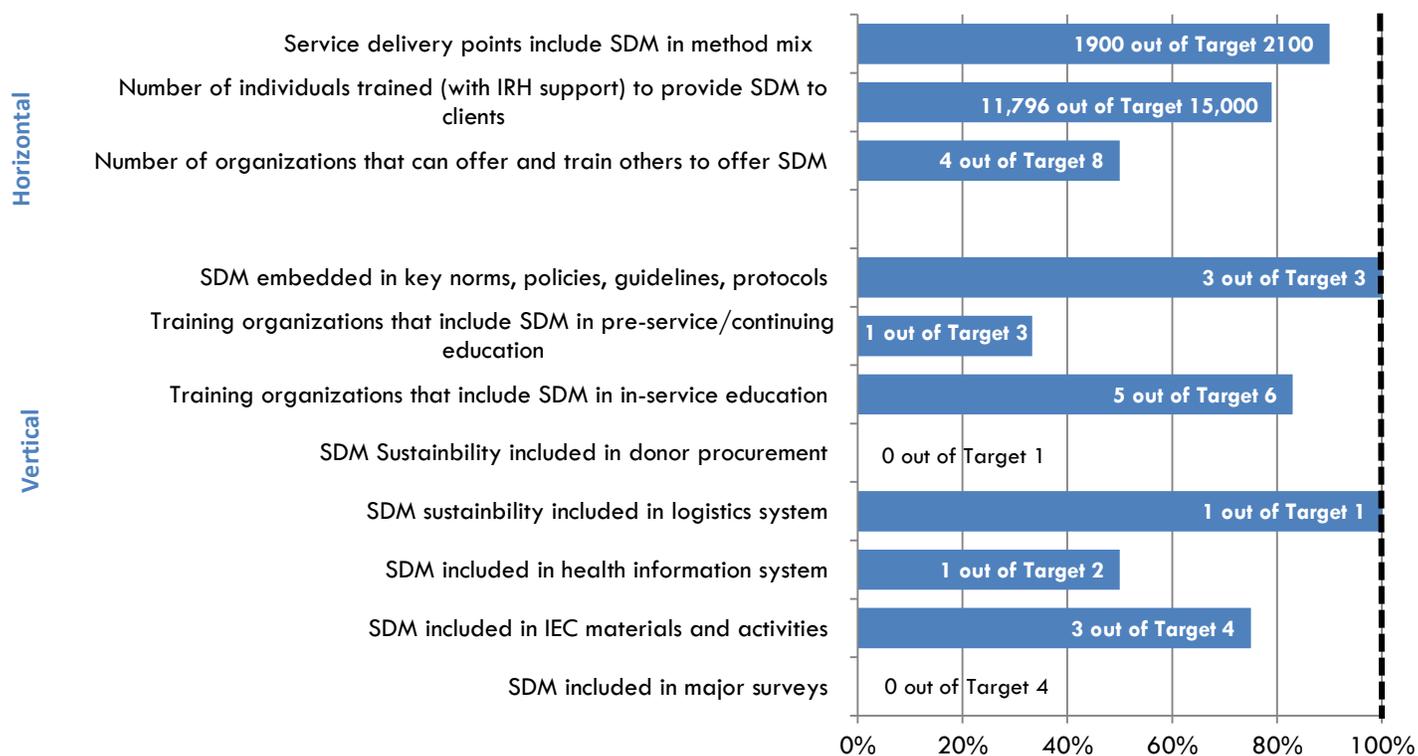
Almost 12,000 out of 15,000 providers were trained and five of six training organizations included SDM in their in-service training curricula. In addition, IRH built the capacity of four of eight service MOHFW delivery organizations to become trainers as well as providers of SDM; these resource organizations are crucial to sustainability. Efforts at the Jharkhand State level to include SDM in norms, policies, guidelines, protocols, as well as the logistics system, were successful. Integration of SDM in IEC radio, client (materials and community activities) was also achieved in three of the four planned programs, including social marketing efforts.

### SELECTED SERVICE PROVISION RESULTS

IRH Facility Surveys



## PROPORTION OF BENCHMARK TARGETS ACHIEVED, JHARKHAND, INDIA



There were some external factors that prevented IRH from achieving 100% of all benchmarks. For example, the Jharkhand MOHFW planned in 2009 to develop training modules for *Sahiyyas*, a new cadre of rural outreach workers, into which a unit on SDM would be integrated. However, there were many delays and the curricula, which included SDM, were not printed until spring 2013, after the IRH endline evaluation. The *Sahiyyas* are now being trained with a new FP module that includes SDM. In the last year of scale-up, when SDM had established a successful track record, IRH was able to focus on pre-service education. Workshops were completed with six academic institutions to equip faculty with resources to integrate SDM in syllabi. At endline, one university had already integrated SDM into the nursing curriculum, and others are likely to follow suit. However, SDM in nursing pre-service curricula at the central level remains to be accomplished as these efforts are led by the GOI, which has yet to recognize SDM in the national FP norms; this is also the reason major surveys have not included SDM.

### Scale-Up and the Jharkhand Environment

Although India's health program is largely decentralized, national policies affect state programs, and this held true for Jharkhand's MOHFW. The main issue affecting scale-up was that SDM was not part of the GOI's FP program.

While Jharkhand's MOHFW decided to integrate SDM into the state's FP program, lack of inclusion of the method in the national program posed challenges to scale-up. For example, unlike other methods CycleBeads distributed through services during the scale-up period were donated by the project as they could not be procured by the state. States procure contraceptives through a central procurement mechanism but, because SDM was not part of the national FP program, the MOHFW could not procure CycleBeads centrally. IRH facilitated meetings with the local manufacturer, HLL

As of May 2013, SDM was being offered in almost 2000 MOHFW facilities, from primary health centers to the sub-centers that serve as peripheral outposts.

Lifecare Ltd and the MOHFW to negotiate procurement of CycleBeads. Still, procurement by the MOHFW did not succeed by the end of the scale-up phase. While the Jharkhand MOHFW keeps track of SDM at the local level, it must follow national requirements for reporting of service statistics using national GOI standard forms which have yet to include SDM. The MOHFW, however worked through this situation by a directive clearing the reporting of SDM users by adding a column in their reporting formats. This meant extra work for providers to record SDM, but was accomplished. These and other instances towards integration efforts indicated that the most effective advocacy

with GOI would be to demonstrate successful scale-up in Jharkhand.

Other environmental factors affected scale-up. There was frequent turnover of Jharkhand MOHFW leaders at state and district level which meant that IRH requested briefing meetings with new leaders to share updates, brief them on SDM scale-up, and gain their support. To overcome the challenge of travelling to remote districts from Ranchi, the state capital, to provide technical assistance, IRH decided to assign a district coordinator in each district. In addition, political instability in the state often put activities on hold or slowed down the process and caused suspension of scale-up activities. Beyond the MOHFW health system, few large-scale non-governmental health networks exist. While NGOs were active in many districts, their donor grants could not include SDM scale-up, and the many private health providers in Jharkhand operated independently. Thus, IRH focused on the MOHFW as the main user organization. Furthermore, the Jharkhand MOHFW had requested SDM scale-up and proved a steadfast partner.

## Resource and User Organizations

IRH's strategy was to expand its reach and impact by working through partnerships with donor agencies, government agencies, institutions, and NGOs. 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, several entities were also 'resource organizations.' This means they could train and supervise others to offer SDM. They could also adapt training content, develop IEC items, engage in demand creation activities, and facilitate information-sharing and mutual capacity-building among peers.

PSI, with funding from IRH, piloted the social marketing of CycleBeads in Deoghar district and sold about 4,000 sets. Jhpiego, IntraHealth, and Futures Group participated actively in partner meetings at the state level, but their projects were located outside of the SDM scale-up districts. Because of the limited role of development partners and in the absence of networks of local NGOs or private providers, the Jharkhand MOHFW became both the main resource organization and the main user organization.

A primary objective of scale-up was for IRH to build the capacity of the Jharkhand MOHFW to serve as its own resource organization, thus contributing significantly to sustainability. To achieve this, it

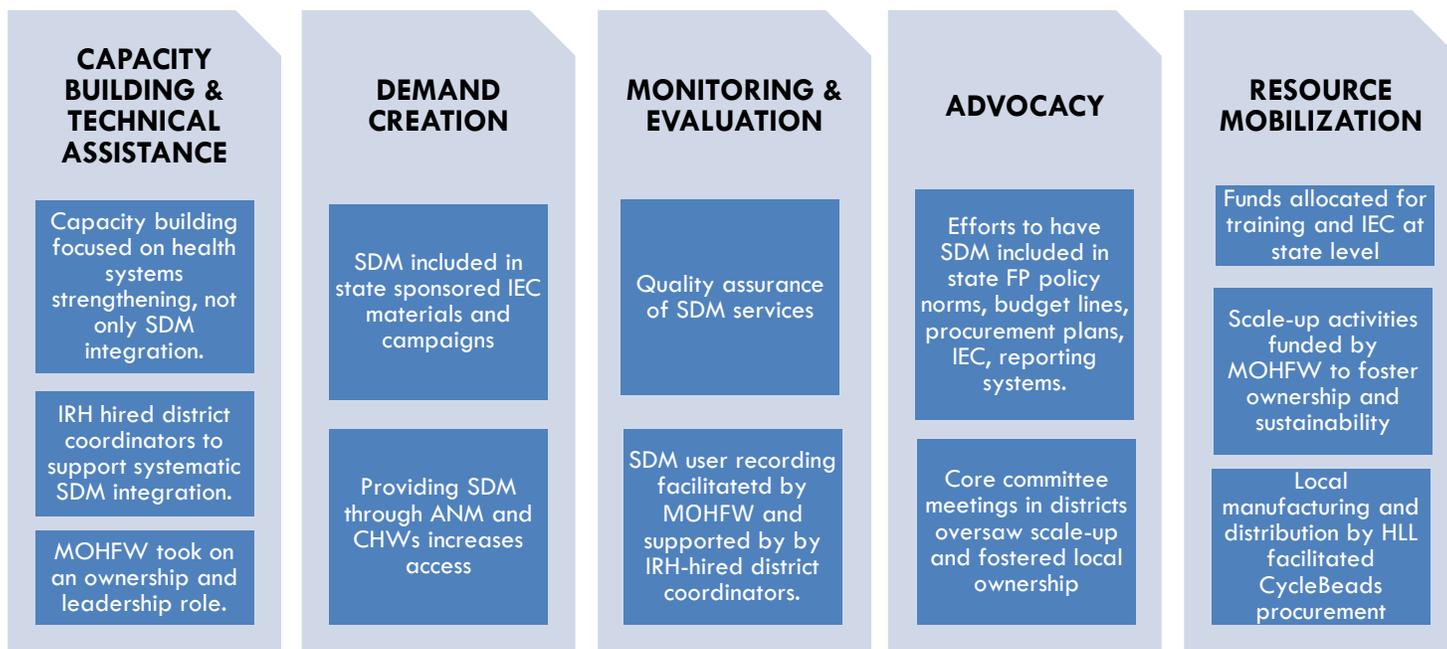
A primary objective of scale-up was for IRH to build the capacity of the Jharkhand MOHFW to serve as its own resource organization, thus contributing significantly to sustainability. State- and district- level partner meetings encouraged MOHFW ownership of, involvement in, and accountability for scale-up planning and management.

was important that key MOHFW personnel be involved in planning and implementing scale-up from the beginning by serving as members of the resource team. Important MOHFW personnel included the Health Secretary, the NRHM Mission Director, Family Planning Cell, the Reproductive and Child Health Officer, and several others all based in Ranchi. IRH's district coordinators worked with district level MOHFW officials, block-level Medical Officers, and program managers, to schedule FP trainings in the district and block, conduct IEC activities and oversee other important components. State- and district-level partner meetings encouraged MOHFW ownership of, involvement in, and accountability for scale-up planning and management.

The Jharkhand MOHFW also represented an ideal user organization because its reach was enormous. It operates an extensive network of health facilities that cover every district and block with support of a new cadre of CHWs called *Sahiyya* that have a presence in every village. Equally important, the MOHFW could set its own FP norms and policies (under the overall aegis of the central government) and had funding for its FP program, increasing the likelihood that integration and scale-up could be sustained. The goal of scale-up was to integrate SDM into the Jharkhand MOHFW's FP services in 12 of its 24 districts, at both facility and community levels. After health system strengthening, training, and training of trainers, this goal was achieved. As of May 2013, SDM was being offered in all facilities from primary health centers to the sub-centers that serve as peripheral outposts.



## Strategic Choice Areas



The ExpandNet framework guides implementers to make strategic choices in several areas based upon their operating environment. These areas, as they applied to scale-up in India, are briefly summarized here.

**Capacity Building and Technical Assistance:** IRH worked to build the capacity of the Jharkhand MOHFW to offer SDM services and to improve the FP program in general. Training MOHFW staff in each district to serve as master trainers was a way to build in-house capacity, strengthen the health system, and ensure sustainability of SDM within the user organization. IRH streamlined SDM training to fit a two-hour time frame within the CTU program schedule to facilitate the method's integration within the existing basket of services. A cascade-training approach, combined with mentoring and monitoring to ensure quality, was employed. IRH's district coordinators worked with district and block authorities to develop the training schedules. Emergence of a new cadre of providers, the *Sahiyyas*, during SDM scale-up resulted in the need for new training approaches. The need to train low-literacy providers prompted a shift to shorter, more structured training methodologies that were implemented in conjunction with new pictorial CycleBeads instructions.

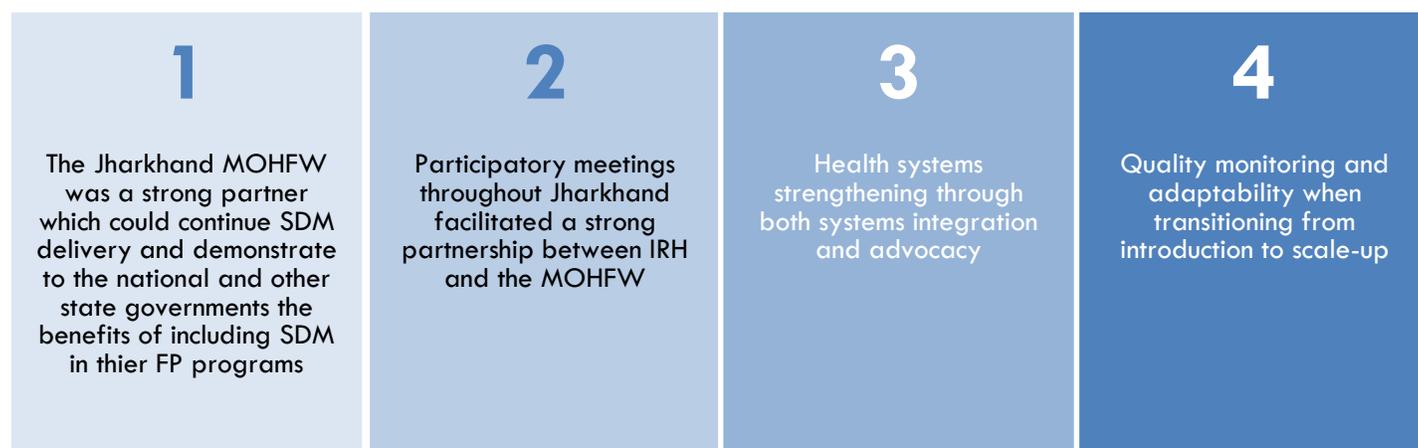
**Monitoring and Evaluation:** Documentation of key elements of the scale-up process and their outcomes included data at the program, provider and client levels. To monitor scale-up, IRH collected data that offered insights into progress in each block. This included comparing providers' CTU post-test scores in a given block with the block's service statistics to identify opportunities to improve their training. Engaging MOHFW officials at state and district levels in regular review of M&E data during partner and one-on-one meetings helped build the capacity of MOHFW staff to collect and use data to make program adjustments.

**Advocacy:** IRH initiated SDM scale-up at the request of the Jharkhand MOHFW, but frequent turnover of officials resulted in a lack of institutional memory within the system. Constant advocacy with MOHFW, involving routine meetings at many levels was essential to ensure ongoing commitment to the process and actions to achieve institutionalization of SDM. IRH's work in various districts and the significant evidence base it built – during both the introductory and scale-up phases – led the MOHFW to perceive it as a credible advocate. The MOU between IRH and the Jharkhand MOHFW in which the government committed to investing more than \$200,000 to SDM scale-up represented a great advocacy success. This demonstrated not only of the government's commitment to the scale-up process, but also their appreciation of the work IRH had done up to that point.

**Resource Mobilization:** IRH received funding from USAID, but scaling up SDM services to approximately 12 million people required additional resources. It was therefore essential to leverage funds. The Jharkhand MOHFW contributed significant resources to scale-up that paid the costs for SDM and CTU trainings of MOHFW providers. It also paid for printing of training curricula and comic books, IEC materials, including items such as World Population Day billboards which included information on SDM. Finally, the MOHFW provided office space to IRH in Ranchi and at most of the districts at no cost.

As a result of IRH advocacy, HLL Lifecare Limited, the largest contraceptive manufacturer in India and a GOI enterprise was established as a producer of CycleBeads. It was important to Indian stakeholders that CycleBeads be manufactured in-country, as procuring CycleBeads from abroad was not an option. HLL signed agreements in December 2009 to become an authorized CycleBeads manufacturer, and further rebranded the product for social marketing and private-sector sales.

## Key Elements that Facilitated Scale-Up in Jharkhand, India



The ExpandNet framework encouraged strategic decision-making that facilitated the scale-up process.

*Choosing the right partner.* Working with the Jharkhand MOHFW was the right choice. It was the largest FP service delivery organization in the state and had its own funds with which it could continue SDM service delivery and training after IRH's involvement ended. In addition, Jharkhand's successful experience in scaling up SDM could demonstrate to the GOI and other state governments the benefits of integrating SDM into their FP program, making scale-up throughout India more likely.

*The importance of reputation.* From the earliest days, IRH organized participatory orientation meetings and trainings, even in the poorest and most distant corners of Jharkhand state where few other organizations would work. This fostered respect and good will on the part of the MOHFW and served scale-up well: it facilitated a strong partnership between IRH and the MOHFW, and opened doors to scale-up opportunities.

*The need to go beyond systems integration.* Integrating SDM into *systems*, such as policies, norms, budgets, procurement, HIS, training curricula, and IEC was essential to sustainability but was not sufficient. Health system strengthening was required as well as ongoing advocacy to ensure that actors within the health system stayed committed to new SDM-related policies.

*Quality control and adaptability during the transition from introduction to scale-up.* In scaling up SDM, it was not possible to apply the same level of resources and monitoring to a huge geographic area with a population of millions. Approaches had to be modified, including simplifying training curricula, CycleBeads user instructions, and counseling guides. Quality monitoring made sure the modified innovation was as effective as the original.

## Sustainability of SDM in Jharkhand, India

Significant progress has been made across the various components of scaling up SDM at the state 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"> <li>Advocate for SDM inclusion in national-level policies and programs</li> <li>Advocate for support for SDM expansion from USAID and other donors</li> </ul>	USAID , HLL and MOHFW MOHFW
CAPACITY BUILDING	<ul style="list-style-type: none"> <li>Ensure SDM is part of FP activities in new procurements</li> <li>Include SDM in state FP training programs &amp; curricula, such as <i>Sahiyya</i> training</li> <li>Expand SDM integration to remaining 12 Jharkhand districts</li> <li>Reinforce SDM/LAM provider competency</li> <li>Integrate SDM in other nursing schools following the example of Jamia Hamdard University.</li> </ul>	USAID MOHFW , USAID MOHFW , USAID MOHFW MOHFW , USAID
LOGISTICS AND PROCUREMENT	<ul style="list-style-type: none"> <li>Purchase CycleBeads from HLL</li> <li>Advocacy for purchase of CycleBeads</li> </ul>	MOHFW USAID and HLL
IEC	<ul style="list-style-type: none"> <li>Ensure SDM and LAM included in IEC materials and campaigns</li> </ul>	USAID and MOHFW
HMIS/ MONITORING & EVALUATION	<ul style="list-style-type: none"> <li>Monitor that SDM and LAM information is completely and correctly recorded in HMIS</li> <li>Ensure HMIS have space included for SDM state-wide</li> <li>Include SDM in next state-wide survey</li> </ul>	MOHFW MOHFW MOHFW, USAID

## Introduction

As a result of dedicated efforts over a period of six years and in spite of many obstacles, Standard Days Method (SDM), a fertility awareness-based family planning (FP) method was integrated into the FP program in 50 percent of the state of Jharkhand, India. SDM is an easy-to-use, economical and effective natural method that identifies the days when a woman is fertile during her menstrual cycle.

Historically, FP programs in India have focused on permanent and long acting methods, such as sterilization and IUD, resulting in a lack of emphasis on birth spacing methods and services within the policy arena and the health system. The Institute of Reproductive Health's (IRH) work to expand access to SDM, described in this report, forms part of a movement to improve FP services as a whole and expand FP choices in Jharkhand.



Figure 1: Map of India

Filled with challenges, successes, and partnerships, the scale up story illustrates what is required to bring an evidence-based, high-impact practice from a small pilot study to reach a coverage area of more than 12 million people. It describes outcomes of activities that aimed to expand access to SDM and strengthen Jharkhand's FP program overall. With lessons applicable to other FP methods and health innovations, it highlights how the **ExpandNet model** for scale-up was used to shape and guide the scale-up process.

## 1. India Context Prior to Scale-Up

### 1.1. India's Jharkhand State

The state of Jharkhand is home to nearly 33 million people,<sup>1</sup> most of whom live in rural areas and have relatively low education and literacy rates.<sup>2</sup> A new state in the Indian union, Jharkhand was created in 2000 from the southern portion of Bihar. The Government of Jharkhand inherited a weak public health system, but the state's newness meant there was an environment in which health policies were not entrenched and government officials were willing to adopt innovative strategies to tackle health challenges.

Jharkhand's reproductive health (RH) data suggested potential demand for new FP methods such as SDM. The state's total fertility rate (TFR) was among the highest in India, and had increased from 2.8 children per woman in 1999 to 3.3 in 2006. The contraceptive prevalence rate (CPR) was low at 35.7 percent (the average in India was 56.3 percent), and was mostly due to female sterilization.<sup>3</sup>

Factors other than the low CPR contributed to the Ministry of Health and Family Welfare's (MOHFW) urgency to increase the availability of birth spacing methods in the state. The infant mortality rate was high, at 69 deaths per 1,000 live births (higher in rural areas) according to

<sup>1</sup> 2011 Census of India. [http://www.censusindia.gov.in/2011-prov-results/data\\_files/india/Final%20PPT%202011\\_chapter3.pdf](http://www.censusindia.gov.in/2011-prov-results/data_files/india/Final%20PPT%202011_chapter3.pdf)

<sup>2</sup> NFHS-3. [http://www.nfhsindia.org/NFHS-3%20Data/Jharkhand\\_report.pdf](http://www.nfhsindia.org/NFHS-3%20Data/Jharkhand_report.pdf)

<sup>3</sup> Ibid.

India's third National Family Health Survey (NFHS-3). Also, the cultural norm of early marriage meant that 63 percent of women aged 20-24 years were married before the legal minimum age of 18. These and other factors pointed to the need for culturally-acceptable methods that could help women delay and space births.

## 1.2. IRH in India Prior to SDM Scale-Up

First, it is important to understand how SDM came to Jharkhand, and how leaders of Jharkhand's MOHFW came to the decision that SDM merited scale-up.

After the report was published in 2002 of the efficacy study of the SDM established in a multi-country study,<sup>4</sup> USAID provided funding to IRH and several Indian organizations to assess the feasibility of introducing SDM in India, believing that a simple, non-hormonal FP method would appeal to many Indian women who wished to delay or space their births. From 2001-2004, IRH conducted two operations-research studies to test the feasibility of offering SDM in community-based RH programs: one was in rural Uttar Pradesh (with CARE in Sitapur district), and the other in Delhi slums (with Community Aid and Sponsorship Program).

Results showed that, in both rural and urban areas, there was a demand for SDM, users were highly satisfied with the method, women liked that it had no side effects or health risks, and it could be easily taught by providers and community health workers (CHW) and correctly used by women.<sup>5</sup>

These results attracted the interest of the Government of India's (GOI) MOHFW and led to the integration of SDM into several national-level documents. The GOI included SDM in a national policy document as a way for FP programs to expand choice (Reproductive and Child Health-Phase Two Plan, 2005), and the United Nations Population Fund (UNFPA) and the GOI included SDM in their Contraceptive Update Manual for medical officers in 2005. Shortly thereafter, SDM attracted the interest of several professional organizations<sup>6</sup>, which featured presentations on SDM at their national conferences starting in 2006.

Interest in SDM within India continued to grow, and IRH began to work with a wider range of partners<sup>7</sup> to integrate SDM into NGO FP initiatives. Among the organizations interested in the SDM as a result of the successful operations research was the MOHFW of the State of Jharkhand.

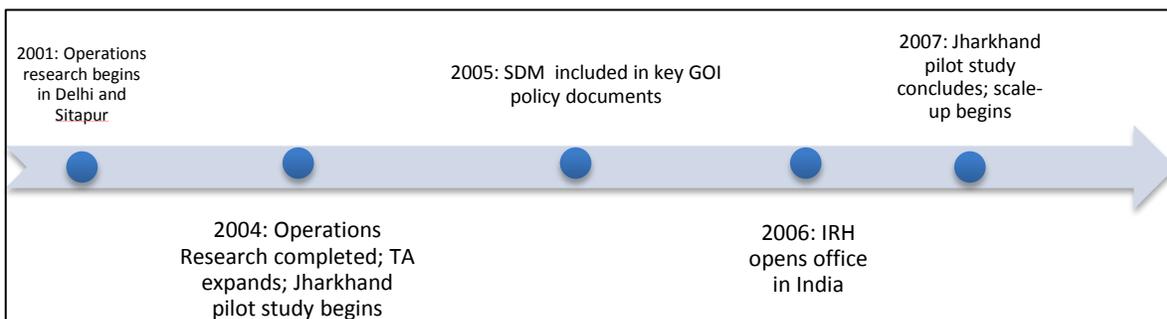


Figure 2: Key SDM Activities in India prior to Scale Up in Jharkhand

<sup>4</sup> Arevalo, 2002

<sup>5</sup> Gribble et al. (Reports of IRH-India's research and project activities from 2001-2007 can be found at [www.irh.org](http://www.irh.org).)

<sup>6</sup> Including the Federation of Obstetric and Gynecological Societies of India and the Indian Medical Association.

<sup>7</sup> Pathfinder in Bihar, Uttari Rajasthan Cooperative Milk Union Ltd/URMUL in Rajasthan, World Vision in Uttar Pradesh, and People's Rural Education Movement/PREM in Orissa.

In 2004, the Jharkhand MOHFW, IRH, and other partners including CEDPA, and Krishi Gram Vikas Kendra (KGVK, a Jharkhand-based NGO that works in health and economic development) jointly designed an introductory phase, funded by USAID, which would test the integration of SDM into the state's RH and child health services/ FP program. The study introduced SDM in public health services (and in private sector services on a very limited basis) in two blocks of Ranchi district with a population of about 200,000; a third block served as a control. This was the first time SDM was offered by public sector health services in India.

The study results (see box) were compelling, and demonstrated that it was feasible to offer SDM in the public sector by all levels of providers. SDM appealed to women who wished to space births, particularly those who had never used a FP method.<sup>8</sup> The Jharkhand introductory phase provided solid evidence to the Jharkhand MOHFW that SDM was a health innovation that would benefit large numbers of people if taken to scale.

#### National FP Program Focus

While the Reproductive and Child Health (RCH) Programme Implementation Plan- II (2005) mentions SDM and LAM as methods that could expand contraceptive choice, the MOHFW does not currently see SDM and LAM as cost-effective methods, and has not allocated resources to expand these. However, while the GoI has discussed expanding choice as one of the strategies for population stabilization, they have not taken any proactive decision on including new methods for many years now. They are currently focused on establishing the existing methods for spacing, through introduction of the PPIUCD or new strategies of social marketing for pills and condoms to promote doorstep delivery of contraceptives. Other methods such as injectables, vaginal rings, implants etc. are also in the pipeline going through research and introductions. The general environment in the GoI does not give space to including new methods.

#### Introductory Phase Study: SDM Integration into Health Services in Jharkhand, 2004-2007:

- 30 percent of new FP users chose SDM.
- About 88 percent of SDM users previously used no FP method, suggesting that the SDM attracts first-time users.
- Simulated client results showed that MOHFW providers, Anganwadi workers, and CHW all provided high-quality SDM services, while community-level workers were key to expanding access.
- Introducing the SDM improved FP counseling overall, especially for condoms.

As the introductory phase drew to a close, IRH communicated the results of various components to MOHFW officials. IRH and the MOHFW held a series of conversations on the results' implications, and through regular meetings and ongoing involvement in processing the study results, the MOHFW decided that SDM, if integrated into the state's FP program, could contribute to increasing CPR in Jharkhand.

In April 2007, IRH and study partners (Jharkhand MOHFW, CEDPA, and KGVK) organized dissemination meetings in Jharkhand and Delhi to share the introductory phase results with development partners and stakeholders, and to engage them in a discussion about their implications. Over 130 people including Jharkhand's Minister of Health and

other MOHFW representatives, and representatives from USAID, development partners and NGOs, participated in these day-long meetings. Journalists also attended, and the event was covered in several newspapers and on several television channels.

At these meetings, Jharkhand MOHFW officials publicly stated their desire to scale up SDM based on to the positive results of the pilot study. While some participants pointed out the potential challenges of scaling up a fertility awareness-based method, attendees at both meetings expressed strong support for the increased availability of SDM. The testimony of SDM providers and users from Jharkhand corroborated the findings and provided additional support for this decision.

<sup>8</sup> Final Report. Jharkhand Impact Study. IRH, 2007.

The timing of Jharkhand MOHFW's decision to scale up SDM (Fall 2007) coincided with the award of the FAM Project to IRH, which came with USAID funding from Washington (core funds) and the mission in India to support scale-up. The relationships that IRH built with Jharkhand MOHFW and other partners during the introductory phase provided a good foundation for this effort.

IRH and the Jharkhand MOHFW continued to meet regularly to develop concrete plans to carry out the latter's stated intention to scale-up SDM.<sup>9</sup> The MOHFW determined that scale-up should take place in steps, with technical assistance from IRH: work would begin in three districts, and two to three more districts would be added each year. At the end of the five-year scale up period, half of Jharkhand's 24 districts would be fully covered. The MOHFW selected Gumla, Deoghar, and Chatra as the first three districts because of their low CPR. In October 2007, the MOHFW issued formal notification letters to the three districts, officially commencing the SDM scale-up phase and the IRH-MOHFW partnership.

These letters gave IRH the green light to begin orientation meetings and conduct master level trainings in the three districts. However, it wasn't until MOHFW officials signed a Memorandum of Understanding with IRH in October 2008 that the government committed to making approximately US \$200,000 in direct expenditures towards scale-up activities, including trainings, materials printing, and CycleBeads procurement. This commitment was an essential component of SDM scale-up in Jharkhand.

## 2. Use of the ExpandNet Model in India

The decision to integrate a new FP method into a program that reached millions of people was not one to be taken lightly or made quickly. Realizing that large-scale expansion of SDM would require a different model from the research-focused introductory phase—not only in India, but in Guatemala, Rwanda, DRC and Mali, where SDM scale-up was also underway—IRH adopted the World Health Organization's **ExpandNet model** for introducing and integrating health innovations. The model guides the conceptualization of the scale-up process, its components and goals, and the technical assistance needed to achieve those goals.

In a two-day meeting in Washington, DC in December 2007, representatives from ExpandNet/WHO provided an orientation on the model to key actors. Representatives from ExpandNet and WHO presented the model. Participants from India were IRH's country representative, Jharkhand MOHFW's National Rural Health Mission (NRHM) Director,<sup>10</sup> and USAID India's FP Technical Advisor. With the guidance of ExpandNet/WHO representatives, participants from India and those based in Washington who supported scale up in India used the ExpandNet guide *Nine steps for developing a scaling-up strategy*<sup>11</sup> to conduct initial planning. Some scale-up decisions had already been made (such as the step-wise geographic expansion), but talking through the questions in the guide helped the team better understand what scale-up would require and enabled them to identify key issues. For example, they learned to see the 'innovation' as more than just CycleBeads, but as a package that included training curricula, educational materials, and monitoring tools. Most innovation components would require some form of adaptation to make them appropriate for wide-scale expansion in Jharkhand (see Section E.1).

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<sup>9</sup> It also decided that Lactational Amenorrhea Method (LAM) should be scaled up alongside SDM. This also happened under IRH's guidance, but LAM is not the subject of this report.

<sup>10</sup> The goal of the National Rural Health Mission is to improve the health of the rural population in 18 of India's neediest states, including Jharkhand. The NRHM Mission Director is the MOHFW official responsible for programmatic oversight of reproductive, maternal and child health issues in the state.

<sup>11</sup> Available at [http://www.who.int/reproductivehealth/publications/strategic\\_approach/9789241500319/en/index.html](http://www.who.int/reproductivehealth/publications/strategic_approach/9789241500319/en/index.html).

Building on this foundation, IRH used the ExpandNet model to inform its work throughout the SDM scale-up phase. In India, IRH oriented all new staff on the model and dedicated time at annual workshops to review scale-up status through the lens of the model. Many of the model’s aspects – for example, the concepts of vertical and horizontal scale-up – became part of the everyday vocabulary of IRH staff in India. Although MOHFW participated in the 2007 planning meeting in Washington, the ExpandNet model thereafter was mainly a tool that IRH used, in its role as technical assistance (TA) group. IRH did not dedicate significant time to using the model with MOHFW representatives in Jharkhand because of the frequent turnover of state and district MOHFW leaders, the large geography distances between most scale-up districts, and the need to prioritize urgent program-related matters in the limited meeting/planning time available with key MOHFW representatives.

The SDM scale-up strategy in India focused on both horizontal and vertical axes of the ExpandNet model.

Horizontal scale-up refers to geographic expansion of an innovation; this occurred in steps as seen in Figure 3. The expansion of SDM and LAM proceeded in phases. First, SDM and LAM were introduced in three districts (Gumla, Chatra and Deoghar) and one block in a fourth district (Pakur) in 2008. Next, the methods were introduced in the remainder of Pakur, Sahibganj, and Dumka districts beginning in March 2010. Finally, the districts of Godda, Koderma, Hazaribag, Jamtara, Khunti, and Ramgarh were added in November 2010 for a total of 12 districts. Activities were coordinated at the Jharkhand State and District levels. An IRH coordinator at the state level in addition to a coordinator per district helped ensure program activities implementation.

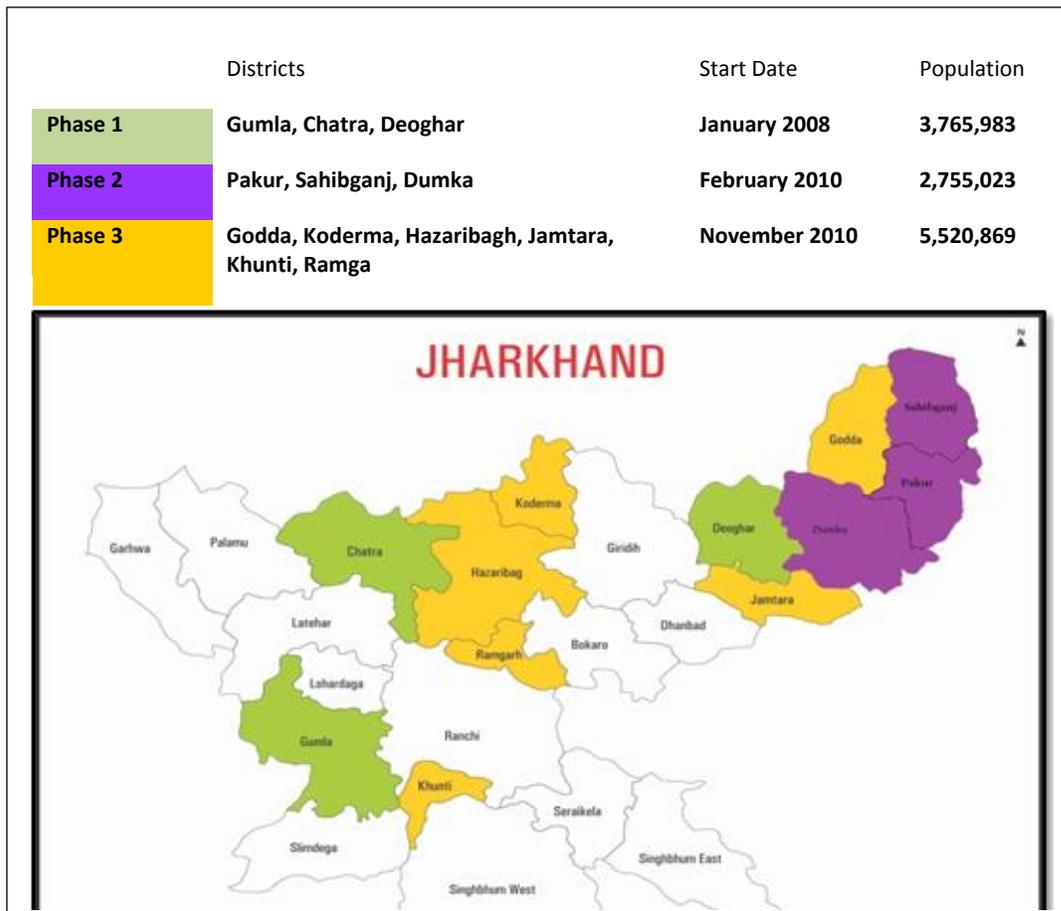


Figure 3: Geographic expansion of the SDM in the State of Jharkhand, India

Vertical scale-up refers to institutionalization. The scale-up strategy called for integration of SDM into *all state systems* required for maintaining sustainable, quality services: policy, budgets, procurement, logistics, health management information systems (HMIS), service delivery, and demand creation. Table 1 shows specific points of integration that were relevant to Jharkhand state. SDM integration was geared toward strengthening the health system, and in particular, the FP program, so that the MOHFW system would be better equipped to provide a full basket of birth spacing methods. Vertical scale-up also entailed advocacy with MOHFW officials to ensure their continued support for the scale-up effort.

SDM scale-up in India was informed by the guiding principles of *systems thinking, sustainability, scalability, and respect for human rights*, as articulated by ExpandNet. Scalability was a key concern and led to streamlining and simplifying the SDM innovation package to make it easier to take to scale. To advance human rights, scale-up attempted to reach the most underserved and isolated segments of the population by working in districts with the greatest need, as identified by the MOHFW and by engaging community level workers to reach remote areas.

IRH’s technical assistance was guided by the value of informed choice, the principle that individuals should have information and access to the full range of FP methods and freely choose a method that best suits their needs. In all its work, IRH spoke of SDM in the context of India’s larger FP method mix, and worked to promote quality and client-centered counseling for all methods.

Gender issues were incorporated by promoting couple communication and collaborative decision-making about FP, directing messages in communication materials towards the couple rather than only the woman, educating women about how to engage with husbands in using the method, and regular program review through the gender lens. Outreach such as a community radio program (pilot initiative in Gumla district) was another way human rights principles were built into SDM scale-up, as these involved community participation, involving men, and attention to gender perspectives.

<b>System component</b>	<b>Example</b>
Norms & protocols	<i>State Programme Implementation Plan, Auxiliary Nurse Midwife (ANM) Guidelines</i>
In-service training	<i>Contraceptive Technology Update (CTU) and other trainings</i>
Pre-service training	<i>Sahiyya, Anganwadi and ANM training centers</i>
Information, Education, Communication (IEC)	<i>State IEC strategy on birth spacing</i>
Commodity procurement & distribution	<i>Procurement of CycleBeads</i>
Monitoring and supervision systems	<i>Strengthening the supervision system</i>
Data collection and reporting	<i>Inclusion of SDM in reporting formats at health sub centres upwards</i>

**Table 1: Examples of SDM Integration Points**

### 3. Data Sources, Collection and Analysis

A variety of data, both quantitative and qualitative, was collected to monitor scale-up and evaluate results. Major data sources and the indicators they assessed are listed in Table 2.

Method	Frequency	Type of Indicator
Household Survey	<i>Twice: Baseline &amp; Endline</i>	<i>Outcome:</i> <ul style="list-style-type: none"> <li>• Awareness and use of SDM</li> <li>• Availability of quality services</li> <li>• Provider competency</li> </ul>
Service statistics	<i>Ongoing</i>	
Knowledge Improvement Tool (KIT), Client Follow Up (CFU)	<i>Semi-annually</i>	
Most Significant Change (MSC) Stories	<i>Once (Year 4)</i>	
Service Delivery Point (SDP) Survey	<i>Twice : Midline &amp; Endline</i>	<i>Output:</i> <ul style="list-style-type: none"> <li>• Providers trained</li> <li>• Clinics offering SDM</li> <li>• Demand-oriented IEC</li> <li>• Supportive partners/ stakeholders</li> <li>• Systems integration</li> </ul>
Stakeholder Interviews	<i>Twice: Baseline &amp; Endline</i>	
Benchmark Tracking	<i>Semi-annually</i>	
Focus Group Discussions with IRH staff	<i>Three times</i>	<i>Process:</i> <ul style="list-style-type: none"> <li>• TA for systems integration</li> <li>• Advocacy</li> <li>• Capacity building</li> <li>• Quality assurance, monitoring, supervision</li> </ul>
Events timeline	<i>Ongoing</i>	
KIT and CFU ( <i>same as under "Outcomes"</i> )	<i>Semi-annually</i>	

Table 2: Monitoring and Evaluation Methods

#### 3.1. Primary Data Collection and Analysis

Surveys were an important method for evaluating scale-up, and included household and facility-based surveys. These were supplemented by qualitative data collection in the form of stakeholder interviews, to facilitate better understanding and interpretation of results.

The **household survey** addressed key questions about knowledge and practice of SDM at baseline (January 2009) and again at endline (August 2012). IRH developed a structured questionnaire based largely on the contraceptive section of the Demographic and Health Surveys, with an additional in-depth module on knowledge and use of fertility-awareness based methods.

The baseline survey was conducted in Gumla, Chhatra, and Deoghar districts, and in one block of Pakur district, among 1,455 married women of reproductive age, and 790 men married to women of reproductive age. This was a true baseline, in the sense that SDM service provision had not yet begun. Analysis emphasized population variables that could guide the intervention, such as cell phone use and exposure to various media.

The **service delivery point (SDP) survey** assessed the status of SDM integration and quality of services at the facility level in mid-2010 (midline) and again in early 2013 (endline), in the same districts as the household survey. The SDP survey consisted of three elements:

- Facility assessment: a visual survey for SDM related commodities and IEC materials, and a short interview with each facility manager to gauge whether SDM services were offered and SDM was included in record keeping and information systems.
- Provider interviews: to assess level of training in and correct understanding of SDM, competency and experience offering SDM, and attitude (including biases) toward SDM in relation to other FP methods.
- CHW interviews: similar to the provider interviews but geared to *sahiyyas*, as CHWs are called in Jharkhand.<sup>12</sup>

At midline, data were collected from 170 providers in 109 facilities and 449 *sahiyyas*, in Gumla, Chatra, and Deoghar. The endline facility study was larger, with 300 providers in 176 facilities and 422 *sahiyyas* interviewed, in the same three districts as well as in Dumka.

- SDM was available at all SDPs visited; nearly all facilities had at least one provider trained to offer FP services, including SDM.
- Most *sahiyyas* interviewed, in both studies, had received training on condom use and SDM, and most had been trained to offer oral contraceptives. Most providers (83 and 87 percent in midline and endline respectively) had offered SDM to women, and reported high client interest.
- Some 92 and 99 percent of facilities reported recording SDM users in midline and endline respectively.
- Providers generally exhibited a good understanding of SDM; the knowledge of *Sahiyyas* at midline was similar to that of clinic-level providers; at endline the knowledge of *Sahiyyas* exceeded those of facility-based providers.

However, the midline SDP assessment also revealed barriers and challenges to effective service delivery:

- Some SDM counseling information was lacking among providers and *sahiyyas*, such as postpartum and post-hormonal eligibility for SDM and, among *sahiyyas*, how to screen for cycle length. This suggested areas to be emphasized during refresher training and supervision visits. The endline study results suggest that the problem was largely resolved among *Sahiyyas*, but not among facility-based providers.
- Regular supervisory visits were lacking, in both midline and endline studies, which could affect quality of services over time.
- Stock-outs of FP commodities were evident at midline. CycleBeads were unavailable in 24 percent of SDP. The pill was unavailable in 30 percent, and condoms in 26 percent. This situation improved, such that at endline only 7 percent of facilities did not have CycleBeads in stock, compared to 9% who did not have condoms.
- *Sahiyyas* were not required to report their activities to the nearest SDP, and this held especially true for FP because FP was not a part of their initial scope of work. Fewer than half of *sahiyyas* recorded or reported their activities at midline (and exactly half at endline), which made accurately tracking FP users a challenge.

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<sup>12</sup> A primary component of NRHM is the placement of a female 'health activist,' called *sahiyya* in Jharkhand, in each village. *Sahiyyas* are volunteers selected by villagers and are required to have an 8<sup>th</sup> grade education. They establish links between communities and health facilities and facilitate referrals. About 41,000 are at work in Jharkhand.

The results of the midline SDP assessment revealed remarkable progress in the capacity of the MOHFW to offer SDM services after two years. At the same time, they also revealed weaknesses in the health system and, in particular, knowledge gaps pertaining to SDM counseling, which the resource team, a small group of individuals in the different districts committed to scaling up SDM, was then able to address. For example, IRH worked with MOHFW district personnel to improve the flow of FP commodities to avoid future stock outs. These lessons were applied to new scale up districts going forward.

The endline SDM assessment suggests that many (but not all) of the problems identified were addressed. For example, stock-outs (of all methods) were not as prevalent. However, there were still gaps in the knowledge of facility-based providers with respect to various aspects of SDM provision. SDM was part of the services offered by *sahiyyas* in 163 of the sites assessed and 73 of the 75 sites had written protocols which included SDM. In 168 of the 176 sites surveyed, SDM users were recorded in the daily registry.

As part of baseline research, IRH conducted in-depth **stakeholder interviews** with government officials, representatives of private voluntary organizations, professional associations, educational and training institutions, donor organizations, USAID cooperating agencies, and other organizations introducing SDM. The interviews included such topics as political commitment to SDM scale-up, political and environmental factors influencing scale-up, SDM knowledge and attitudes, ability of the Jharkhand MOHFW to manage scale-up, and the degree of SDM integration into annual planning and budgeting processes.

*"[FP/birth spacing] is not a priority of the Government here. In NFHS-2, complete immunization was 8 percent, and now in NFHS-3 it is 39 percent because the entire system was geared up to work on immunization. There is a core group [of development partners] who work for immunization. The Government has created this group. Now, if the Government creates a similar core group for birth spacing, only then can it become a priority."*

–Stakeholder Interview, 2009

Interviews were repeated at endline, and a shift in attitudes was evident. At baseline, stakeholders were skeptical about SDM integration, fearing that it would take too much time to train and offer the method. At endline, by contrast, the interviewed stakeholders recognized the need to continue training providers, especially *sahiyyas*.

#### Most Significant Changes as a Result of SDM Integration

From the perspective of users, SDM (18 stories)

- Helped women establish communication about FP with their husbands
- Allowed a FP option for women who favor NFP

From the program managers perspective, SDM (12 stories)

- Encouraged managers to discuss LAM with post-partum clients
- Encouraged manager to incorporate LAM counseling in post-partum services
- Improved their program image

From the provider perspectives, SDM (15 stories)

- Improved provider knowledge of fertility
- Encouraged health center/providers to collaborate with religious institutions
- Offer an option for clients discouraged from using other methods due to religious beliefs

*"Earlier I had the misconception that women could get pregnant during menstrual bleeding only, but I was wrong and knowledge about SDM helped me understand fertile and unfertile days better."* -Provider, India

The Most Significant Change technique (MSC) is an inductive, indicator-free, participatory evaluation method that complements deductive methods. MSC involves gathering stories from those most immediately involved (FP clients, clinic staff, program managers), around predefined "domains of change."<sup>13</sup> In the case of Jharkhand, the three

domains chosen were: (1) changes in the lives of SDM users; (2) changes signaled by service providers since SDM introduction; and (3) changes noted by program managers since SDM was integrated. After MSC stories were collected, IRH followed a systematic process that enabled the MOH to select the most significant of the stories. By allowing respondents to describe outcomes that they value, MSC can uncover scale-up processes and effects not detected by quantitative data and elucidate intangible aspects of SDM scale-up such as advocacy, champions, leadership, gender equity and informed choice.

### 3.2. Routine Monitoring and Evaluation

IRH routinely collected **service statistics** from health facilities in the intervention areas, including the number of new users of any FP method. This allowed IRH to monitor SDM uptake as well as the spread of SDM services for each district, in comparison to other FP services. The figures, which include CHW service data, were tabulated monthly, and analysis demonstrated trends over time, per month or quarter, per district.

IRH periodically administered its **Knowledge Improvement Tool** (KIT), a supervision tool designed to measure and enhance provider competency, to health workers trained in SDM. The Client Follow Up (CFU) tool was a client interview administered periodically in conjunction with the KIT to ensure that clients were using SDM correctly and with satisfaction. Data were tabulated by district and by block, and were used to (a) verify that the innovation components remained effective as they were scaled-up and (b) identify which areas needed more follow-up supervision. These tools and several results are further discussed in Section F.1.a.

IRH developed a set of **benchmark indicators** and realistic targets for each of the five countries in which SDM scale-up occurred. In India, IRH and partners decided upon benchmarks that were measurable and easy to operationalize, and upon targets that were realistic projections of scale-up achievements at the end of five years. Twice a year, IRH aggregated data into tables in a purpose-built ACCESS database, and current figures were compared to the pre-established benchmarks. Staff evaluated progress and identified problems. Regular data review guided mid-stream adjustments to scale-up in India, and allowed for a global evaluation of scale-up. See Section D for a comprehensive discussion of IRH achievements in India by benchmark indicator.

A **key event timeline** documented key events, internal and external, that positively or negatively influenced SDM scale-up. The timeline offered a 'high-level' view of scale-up and

#### HOW SUCCESSFUL WAS SCALE-UP OF SDM IN JHARKHAND, INDIA?

As of May 2013:

##### SERVICE EXPANSION

SDM services are available in 1900 service delivery points in the state of Jharkhand.

Four organizations are able to build others' capacity to offer SDM.

##### INSTITUTIONALIZATION

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

- Norms, policies, guidelines
- in-service training curricula
- Logistics system
- Health Information reporting system

##### SDM USERS & KNOWLEDGE OF SDM OPTION

49.1% of women and 43.7% of men interviewed in Jharkhand heard of SDM at endline.

Among women using FP at endline, about 5.8% were using SDM.

provided information that was not captured by other tools, such as:

- Key accomplishments in horizontal scale-up (expanding access to SDM), such as major training events held by IRH or partners.
- Coordination of the scale up process, e.g., annual partner or resource team meetings, important meetings with MOH or donors.
- Achievements in vertical scale-up (institutionalization) such as integration of SDM into a nursing pre-service curriculum or into the DHS.
- Political events such as a change in MOH leadership.
- Natural or other emergencies, such as a government declaration of famine or coup d'état.
- Publication of research that included SDM findings.

IRH staff listed events as they happened. Twice a year they were entered into a specially designed Excel spreadsheet that displayed them on a timeline. Viewed in conjunction with all other scale-up data, the timeline assisted in interpretation of results.

### 3.3. Endline Research

#### 3.3.1. Stakeholder Interviews

In June 2012, 19 in-depth interviews were held with selected stakeholders in Delhi and Jharkhand who are active in or familiar with SDM scale-up. The stakeholders included policymakers, program managers and providers in the public sector and development partners and other organizations representing donors, implementing partners, a university and a parastatal. The objectives of the stakeholder interviews in India were to: a) Understand stakeholders' views and definitions of scale-up, particularly SDM scale-up; b) Determine stakeholders' perspective of the extent of success or failure of SDM scale-up, and analysis of factors that have affected scale-up success or failure; c) evaluate changes, and cause of changes, in attitudes of stakeholders regarding SDM integrating the method into their programs; d) determine stakeholders' current commitment and attitudes toward SDM; and determine what still must be accomplished to complete SDM scale-up.

Interviewees indicated that IRH employed a participatory approach by working with a range of stakeholders and that IRH had worked within the existing health system. They appreciated that the scale-up approach employed by IRH allowed for "learning," which is generally not the model used to scale up health interventions in India. The strategic support that IRH-India staff provided was considered critical to convincing the Government of Jharkhand to initiate SDM integration. The evidence that IRH has generated can be used to advocate with the Government of India for further expansion of the SDM into the national program.

Interviewees said that SDM is now considered an important part of the method mix in Jharkhand that expands the basket of choices for contraception. They felt that expanded contraceptive choice is needed in India, given its highly skewed contraceptive method mix that favors female sterilization. SDM was uniformly described positively as a natural method, with no side effects and easy to use. "No injection, no insertion and no operation" was a common refrain. These attributes make it particularly appropriate for the cultural context in Jharkhand and other northern states. Program managers and providers would like to see more awareness-raising for SDM, as well as for spacing methods generally. They advised that the providers best positioned for SDM provision in Jharkhand are *Sahiyas*.

Interviewees noted that CycleBeads procurement is critical to the sustainability of SDM in Jharkhand. Procurement of contraceptives is viewed as the GOI's responsibility, though some

creative alternatives, such as getting HLL to request from the central government that it be allowed to sell CycleBeads to the State of Jharkhand, may be possible. They recommend that IRH work closely with other implementing organizations to provide the evidence base to advocate for the inclusion of SDM on the list of approved contraceptives for procurement by the national FP program.

### 3.3.2. Household Surveys

In February and March of 2013 Gfk Mode, a New Delhi-based research organization, conducted the endline survey in the same three districts as the baseline (Gumla, Chhatra, and Deoghar), plus one additional district (Dumka). This allowed a comparison of baseline and endline figures for the three original intervention districts, and examination of a district where SDM services had been introduced more recently. Surveys were administered to 1,809 married women of reproductive age, and 1,632 men married to women of reproductive age, using the same instruments and similar procedures to the baseline. GfK Mode used a survey instrument – a household questionnaire with modules for women, men, and household - to assess awareness of FP in general and SDM in particular, as well as current and ever use of SDM, while controlling for demographic characteristics. Overall contraceptive prevalence and shifts in the use of methods were compared from baseline to endline.

#### Awareness and Use

The endline survey found that awareness of FP in general was quite high, and that awareness of SDM had increased dramatically over the course of the scale-up phase. Nearly all interviewees (99.7% of women and 93.1% of men) had heard of at least one modern method of family planning. Female sterilization (98.5%) and male sterilization (91%) were the most commonly cited methods, and oral contraceptives (83.2%), IUDs (59.7%), and condoms (82.5%) were also well-known. At 45.6%, awareness of SDM compared favorably to another recently introduced method, the injectable (50.85%). Interviewees had heard of SDM primarily from providers who work in health care facilities (53.7% of women), *sahiyyas* (48% of women and 27.8% of men), posters in health care facilities (36.4% of men) and health talks (31.4% of women and 27.2% of men).

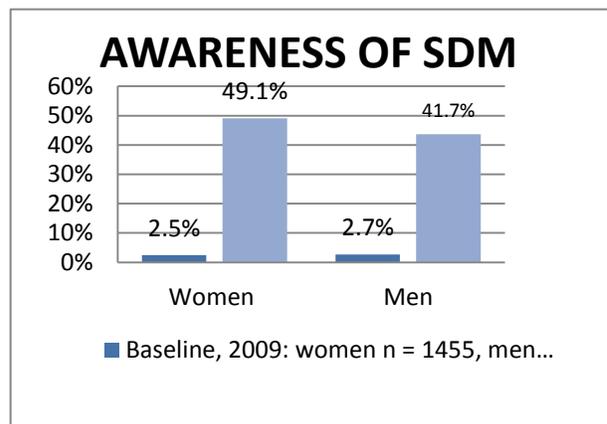


Table 3: Awareness of SDM

The baseline survey was undertaken before SDM services became available. Only 2.5% of women and 2.7% of men reported that they had heard of SDM and only 4 women (0.3%) and 1 man (<0.1%) in that survey reported that they ever used the SDM. In contrast, at the endline survey 49.1% of women and 41.7% of men had heard of SDM. 6.3% of women and 9.9% of men had ever used the method.

At baseline, 48.0% of women and 49.7% of men were currently using a FP method; this increased to 58.4% of women and 56.3% in the endline survey. Among this subset of respondents who were currently practicing FP, 6.0% of women and 7.2% of men were currently using SDM. This is consistent with the expected usage rates based on previous studies<sup>1</sup>. The most commonly used FP method was female sterilization, which 31.5% of all women and 53.8% of women using family

planning were currently using. Condoms, oral contraceptives, and traditional methods were the next most commonly used methods, followed by SDM.

### *Social Diffusion and Attitudes*

315 women reported that they had spoken to someone else about SDM. They spoke to their spouse (64.8%), Provider (28.6%), Mother (2.5%), Mother-in-law (7.6%), Sister (6.7%), other relatives (18.75%), and friend or neighbor (51.1%). Table 4 shows the attitudes towards/opinions of SDM among respondents who had heard of the method. Overall, a majority had favorable attitudes towards SDM's attributes in most categories, and attitudes were more favorable among women who had ever used SDM than those who had not.

	NEVER USED SDM (n=774)	EVER USED SDM (n=114)
Easy to understand	70.3%	93.0%
Easy for partner to understand	61.0%	79.8%
Easy to use	68.3%	89.5%
Effective in preventing pregnancy	60.2%	90.4%
Affordable	50.3%	76.3%
Easy to obtain	61.1%	83.3%
Compatible with religion	72.2%	85.1%
Acceptable to men	52.2%	79.8%
Has no side effects	30.1%	45.6%
No health problems	30.4%	47.4%
Interferes with sex	24.3%	40.4%

**Table 4: Respondents who have heard of SDM: Percent who state that SDM is ...**

### Service Provider Capacity and Method Availability

SDM knowledge and skill among service providers were measured through systematic use of a competency checklist during ongoing program supervision and endline facility assessments. Endline surveys with providers found that 98% were aware of SDM and 87% had offered it in the last year. Assessments of over 2500 providers during regular supervision found that the mean score for knowledge about how CycleBeads work was 84% and their ability to screen for cycle length criterion for the method was 88.7% combined for physicians, nurses, ANMs and community workers. Recording of SDM users was reported by 67% of service providers interviewed during the endline survey.

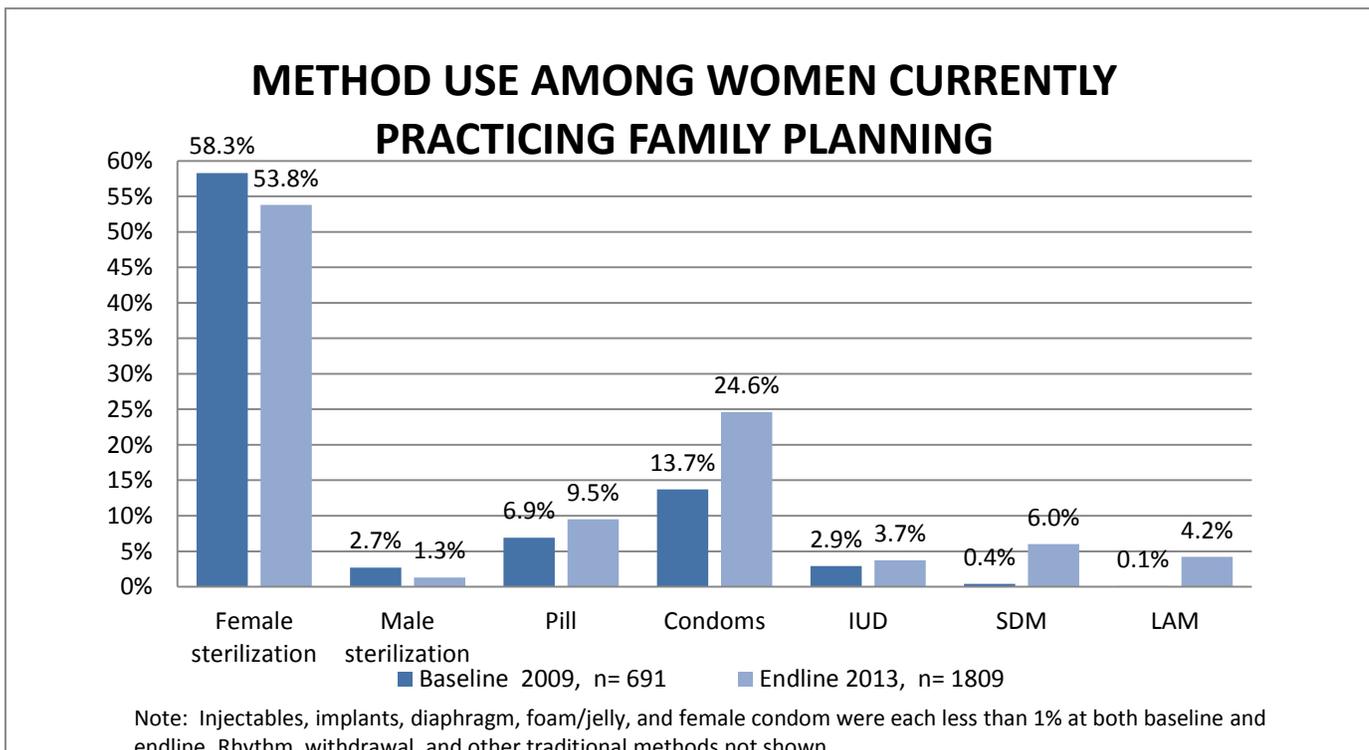


Table 5: Method use among women currently practicing Family Planning

Most SDM users obtained CycleBeads from either health care facilities or *sahiyyas*, and most did not pay for them. Among women who reported that they were currently or had ever used SDM at either baseline or endline, 56.7% obtained CycleBeads from a provider at a health care facility; 40.3% obtained them from a *sahiyya*; 1.5% obtained them from a pharmacy, and 1.5% obtained them from a family member or friend (n=67). About 95% got their CycleBeads for free (n=63).

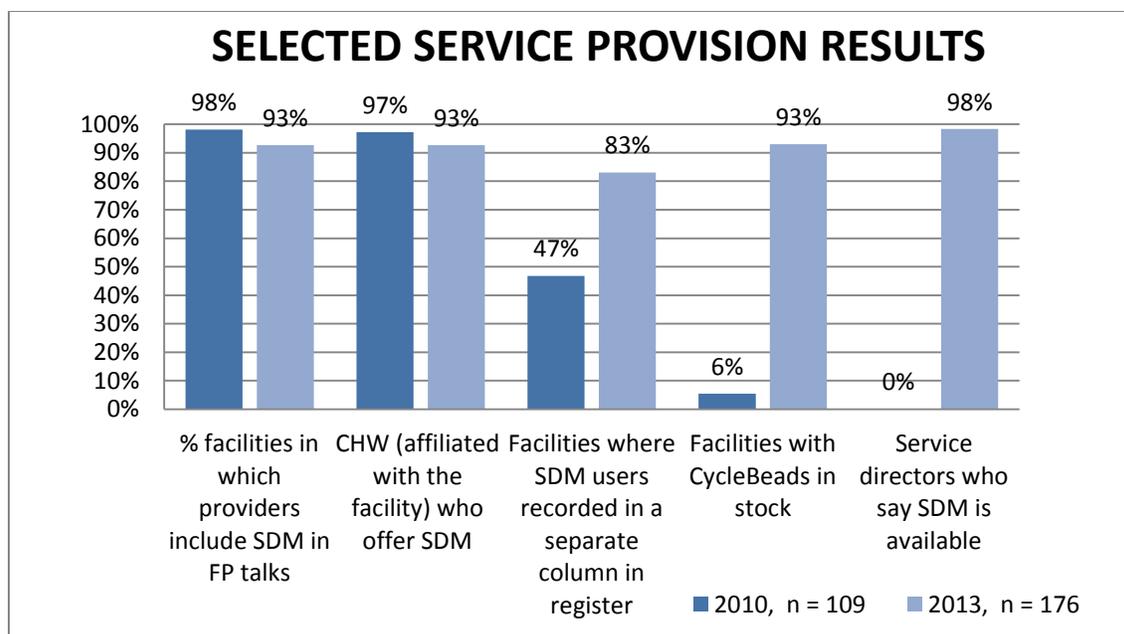


Table 6: Selected Service Provision Results

#### 4. Summary Assessment of SDM Scale-Up

Table 3 presents the substantial achievements in SDM scale-up against the benchmark targets that IRH set for India, along both the horizontal and vertical scale-up axes. The table is followed by a brief discussion of each indicator.

India End of Project Goals:							
<ol style="list-style-type: none"> <li>By 2012, SDM will be available at the SDP and community levels in 12 of 24 districts.</li> <li>By 2012, 40 percent of women of reproductive age in 12 of the 24 districts will have heard of SDM.</li> </ol>							
Horizontal scale-up*	Year 1 2007	Year 2	Year 3	Year 4	Year 5	Year 6 Through 03/ 2013	End of project target (n)
Proportion of <b>SDPs that include SDM</b> as part of the method mix	375 (18%)	570 (27%)	850 (40%)	1,900 (90%)	1,900 (90%)	1,900 (90%)	2,100
Estimated number of <b>individuals trained</b> to counsel clients in SDM (IRH-supported)	1,000 (7%)	2,950 (20%)	5,600 (37%)	7,600 (51%)	10,620 (71%)	11,793 (78.6%)	15,000

Number of <b>organizations that have capacity</b> to undertake SDM activities (are resource organizations)	0	2 (20%)	3 (38%)	3 (38%)	4 (50%)	4 (50%)	8
<b>Vertical scale-up</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>	<b>Year 5</b>	<b>Year 6</b>	<b>End of project target (n)</b>
SDM included in essential or <b>key policies</b> , norms, guidelines, and protocols	0	1 (33%)	2 (67%)	3 (100%)	3 (100%)	3 (100%)	3
Presence of public or private training organizations that include SDM in <b>pre-service training</b> and/or continuing education	0	0	0	1 (33%)	1 (33%)	1 (33%)	3
Presence of public or private training organizations that include SDM in <b>in-service training</b>	0	2 (33%)	4 (67%)	4 (67%)	5 (83%)	5 (83%)	6
Sustainable inclusion of <b>CycleBeads in donor</b> procurement system	0	0	0	0	0	0	1
Sustainable inclusion of <b>CycleBeads in logistics</b> systems	0	1 (100%)	1 (100%)	1 (100%)	1 (100%)	1 (100%)	1
Inclusion of <b>SDM in HMIS</b> /reporting systems	0	0	0	0	1 (50%)	1 (50%)	2
Inclusion of <b>SDM in IEC activities</b> , materials and mass media	1 (25%)	2 (50%)	2 (50%)	2 (50%)	3 (75%)	3 (75%)	4
<b>3.0.6</b> Inclusion of <b>SDM methods in surveys</b>	0	0	0	0	0	0	4
<p>* <b>Horizontal scale-up numbers and percentages are cumulative; percentages are based on end of project targets</b></p> <p>** <b>Year one includes AWARENESS accomplishments</b></p>							

Table 7: India (Jharkhand) SDM Benchmarks (2007-2013)

#### 4.1. Horizontal Scale-Up or Geographic Expansion

Proportion of SDPs that include SDM as part of the method mix

IRH set a target of 2100 SDPs offering SDM by the end of the scale-up phase. The SDP target included a mix of health centers, sub-centers, and community workers. SDM is now offered in 1900 SDPs, representing 90% of the target. However, it should be noted that two of the districts selected for scale-up in the third phase (2010) were smaller districts than projected, and the number of SDPs and providers was therefore lesser than the projections made in 2007- 2008. The success rate could thus be considered to be higher than 90%.

Estimated number of individuals trained to counsel clients in SDM (IRH-supported)

A total of 11,796 individuals in Jharkhand were trained to counsel clients on SDM, which represents 79% of the target 15,000. Of these, 3355 were *sahiyyas*. The *sahiyyas* from 3 (initial) districts were trained. The other districts could not be trained due to lack of funds to cover those. See Section F.1.a. for information on the training process in Jharkhand.

Number of organizations that have capacity to undertake SDM activities (are resource organizations)

IRH aimed to develop capacity to undertake SDM activities in eight organizations, and achieved 50 percent of this target. These include the social marketing organizations such as PSI and HLPPT (this was in Uttar Pradesh and not included in the benchmark table). Other than MOH and PSI, the resource organizations in Deoghar are JHPIEGO and NEEDS. Resource and user organizations are discussed in Sections E.3 and E.4.

#### 4.2. Vertical Scale-Up or Integration

SDM included in essential or key policies, norms, guidelines, and protocols

SDM was effectively included in three key standards and policies in India: at the State level. These represent 100 percent of IRH's target for this benchmark.

Presence of public or private training organizations that include SDM in pre-service training and/or continuing education

In the last year of FAM scale-up, IRH was able to focus efforts on supporting SDM inclusion in pre-service education. Workshops were completed with six academic institutions, though at the time of the endline survey only the School of Nursing at Jamia Hamdard University had integrated SDM into the curricula. Other anticipated pre-service training of ANMs and Medical Officers could not be completed as these were led centrally and not at state level. See Section F.1.b. for more on this topic.

### Presence of public or private training organizations that include SDM in in-service training

IRH advocacy and technical assistance resulted in the inclusion of SDM in five of the six planned in-service training activities with the GoJ, representing 83% of the target of 6. By the end of 2012, the *Sahiyya* training module developed by the GoJ-MRHM included both SDM and LAM in the FP section. SDM was included in the Integrated Skills Development Program (ISDP) for medical officers as well as in the CTU plans for Medical Officer and ANMs. *Sahiyyas*. See Section F.1.a for more details on this process.

### Sustainable inclusion of CycleBeads in donor procurement system

While IRH succeeded in obtaining financing from the Jharkhand FP program for SDM training, advocacy efforts to include CycleBeads in the MOHFW procurement system were not as successful. Funds for NRHM are approved at the national level, and as SDM is not yet part of the national FP program, funding for CycleBeads procurement was not obtained.. Despite extensive advocacy efforts, procurement by the Government of Jharkhand could not be completed during the life of the project. See Section F.3 for a discussion of CycleBeads Procurement in India.

### Sustainable inclusion of CycleBeads in logistics systems

IRH succeeded in including CycleBeads in the districts logistics system, thereby achieving 100 percent of target. CycleBeads have been included in the logistic system from the state to the district to block and HSC level just as other products are, with indents and outflow as per requirements and availability. However, the logistics system as a whole needs strengthening, as stock-outs of many FP commodities, including CycleBeads, occurred throughout the scale-up phase.

### Inclusion of SDM in MIS/reporting systems

SDM included in the reporting forms from state, district and block levels.

### Inclusion of SDM in IEC activities, materials and mass media

Social marketing campaigns by PSI and HLL included SDM messages. An SDM brochure was locally produced and community level activities were carried out to raise awareness of the method, including events at World Population Day. Section F.2 offers a detailed discussion of SDM awareness-raising and demand creation in India.

### Inclusion of SDM in surveys

IRH target was to include SDM in the three surveys that take place in India: the District Level Household & Facility Survey and the Annual Health Survey were conducted at least once during the scale-up phase but did not include SDM. The National Family Health Survey was not conducted

during this timeframe. Despite advocacy by IRH and USAID/India for the inclusion of SDM in four major national surveys, no success was achieved on this target.

## 5. Analysis of Scale-Up as Function of ExpandNet Elements

This section discusses the scale up process by component, using the ExpandNet model as a framework.

### 5.1. How the SDM Innovation Evolved during Scale-Up

The SDM innovation was a package consisting not only of CycleBeads, but of related training modules and materials, provider counseling aids, monitoring tools, client handouts, and outreach materials.

Although SDM integration was successfully tested in Jharkhand in the introductory phase, one of the biggest differences between introduction and scale-up is the amount of resources – including time and money – that can be dedicated to each geographical area. While introduction zones received concentrated focus and resources, it was impossible to sustain that level of support as the SDM coverage increased from areas with a population of 200,000 to districts with combined populations of over 12 million. . Early in the scale-up phase, components of the innovation were be simplified and streamlined so that SDM could be more readily integrated into existing training and service delivery programs, and be easily understandable to providers and users with low education levels. A key finding from the introductory phase was that community health workers reliably offer SDM and could play a critical role in expanding the availability of SDM by providing it in rural areas. In Jharkhand, a group of CHWs known as *Sahiyya* provide an array of health services to rural populations. As many *Sahiyya* have only an eighth grade education, training methods and counseling aids needed to be tailored to meet their needs.

Table 4 shows how various components of the innovation evolved as SDM was taken to scale. The right-most column refers to the *attributes of the innovation* that, per ExpandNet, determine its scalability, including its credibility, relevance, advantage over existing practice, ease of integration, compatibility with norms and values, and testability.<sup>14</sup>

Innovation component	Introductory phase	Scale-up phase	Reason for change
Training module design	Text-heavy training manual suitable for 1-2 day trainings	2-hour ‘storyboard’ manual that was shorter, more structured, easier to comprehend, contained participatory learning activities, and was designed to work with new CycleBeads	<ul style="list-style-type: none"> <li>This increased the <b>ease of transfer</b> and <b>scalability</b> of the innovation because it was easier for the user organization (MOHFW) to implement.</li> </ul>

<sup>14</sup> Nine-step guide, pp. 10-11

		insert	
Counseling protocol	Method screening called for an arithmetical calculation of cycle length to ensure eligibility	Cycle length calculation was replaced with cycle length estimation (women with periods about a month apart could use the method)	<ul style="list-style-type: none"> <li>• This simplification enhanced <b>scalability</b> and <b>ease of transfer</b>.</li> <li>• It was <b>credible</b>: a prior study<sup>15</sup> determined that cycle length calculation did not yield better screening results than estimation of cycle length.</li> </ul>
Training handouts and counseling aids	Participant handout packet; text-based provider job aid in Hindi	A set of comics depicting five SDM counseling scenarios, to serve as a training handout and counseling guide.	<ul style="list-style-type: none"> <li>• Improve <b>compatibility</b> with the user organization and population because the comic books were easy to comprehend and enjoyable to use during counseling.</li> <li>• In this simplification, one product served the dual purpose of a training material and counseling aid, increasing <b>ease of transfer</b>.</li> </ul>
CycleBeads insert	Booklet-style, text-heavy Hindi insert	Fold-out insert, mostly pictorial, suitable for low-literacy readers	<ul style="list-style-type: none"> <li>• This increased the <b>compatibility</b> with the literacy level of the population.</li> </ul>
KIT, a checklist to verify provider knowledge and skill, used for quality assurance	KIT geared towards clinic-level providers, based on counseling protocol used in pilot study.	KIT adapted for use with all levels of providers and to reflect revised counseling protocol. All-method KITs developed. Healthy Timing and Spacing of Pregnancies (HTSP) messages added.	<ul style="list-style-type: none"> <li>• This improved <b>compatibility</b> so that the KIT could be used with CHWs.</li> <li>• The incorporation of HTSP messages and implementation of KITs for other methods was <b>relevant</b> to the health needs of the population.</li> </ul>

Table 8: Adaptations Made to SDM Innovation Package during Scale-Up

<sup>15</sup> Reference the SDM Screening Study report.

A particularly innovative adaptation was the use of comic books that served as both **training and counseling aids**. The comics were colorful, picture-heavy, easy to read and understand, and they educated and entertained at the same time. They were appealing to providers and clients alike. The development of these comic books was an iterative process that involved multiple field tests and took several years, but resulted in an useful, appealing product that was relevant to the population and could be scaled up.



Figure 4: Sample images from comic book (not to scale)

IRH, in collaboration with MOHFW, developed and implemented **tools to monitor and ensure service quality**. These were the KIT and the Client Follow Up (CFU) form. IRH used the tools to ascertain that new or adapted innovation components were effective in the initial scale-up districts before being used in additional districts. IRH also used them throughout the scale-up phase to detect desired outcomes (competent staff and knowledgeable users) and to identify where and what additional technical assistance was required. KIT and CFU are further discussed in Section F.1.a.

A crucial component of the package of innovations was the **CycleBeads**, the visual tool that enabled women and their partners to use SDM. Since 2004, CycleBeads in India were called *Mala Chakra* (Hindi for CycleBeads). The design and look of CycleBeads did not change between the introductory and the scale-up phases, although the instructions that came with CycleBeads were revised to be more user-friendly. It is also important to note that the *source* of CycleBeads did change between the two phases, which had important implications for scale-up. The story of CycleBeads manufacture and procurement is told in Section F.3.

An advantage to adding districts in phases was the opportunity to apply lessons learned. For example, by the time IRH began work in the last six districts, it had developed and/or adapted the training curricula, comic books, monitoring tools and processes (KIT and CFU) and could rapidly implement them.

## 5.2. Effect of Environment on Scale-Up

In the ExpandNet model, the environment refers to “the conditions and institutions which are external to the user organization but fundamentally affect the prospects for scaling up.”<sup>16</sup>

<sup>16</sup> ExpandNet and WHO. “Nine Steps for Developing a Scaling-Up Strategy.” p. 7.

Environmental factors within and outside Jharkhand posed considerable challenges to SDM scale-up.

### 5.2.1. GOI health priorities

India's health program was decentralized: health is a state subject, and state MOHs had a certain degree of autonomy in their FP and other health programs. Nevertheless, state programs were affected by national policies, and this held true for Jharkhand's MOHFW. The main national issue that affected scale-up was that *SDM was not part of the GOI's official FP program*. The national FP program has historically emphasized sterilization, and when it has come to spacing methods, national-level policy makers have tended to favor long-acting methods such as the IUD.

*"[SDM] is definitely a choice for the women. Whatever I have heard of the program in Gumla, there is acceptance in the community. But choice is not everything; it has to be accepted at a larger scale by the Government of India and that has not happened as yet."*

*—MOHFW program manager, 2009*

The national MOHFW's population policy called for bringing the TFR to replacement level by 2020, ensuring universal access to information and counseling, and offering a wide basket of FP options.<sup>17</sup> Yet no fertility awareness-based methods were included among the choices in the national program and, although SDM was mentioned in several GOI documents in 2005, it was not favored by the administration that was in office during the scale-up phase (2007 onwards).

Because the public health sector in India was decentralized, Jharkhand's MOHFW had the authority to integrate SDM into its FP program even though the method was not part of the national program. Still, SDM's absence from the national program posed barriers to scale-up. For example:

- *Procurement*: States procured contraceptives through a central procurement mechanism. Because SDM was not part of the national FP program, the Jharkhand MOHFW could not procure CycleBeads in the same way it procured other methods. To get around this, IRH facilitated a direct relationship between Jharkhand MOHFW and an Indian manufacturer for direct procurement of CycleBeads. Still, procurement by the Jharkhand MOHFW was not in place by the end of the scale-up phase. See Section F.3.
- *Service statistics*: The state MOHFW was obliged to use the GOI's standard formats for reporting FP service statistics, but SDM was not included in these formats. For districts that used paper-based formats, health workers hand wrote a column for SDM. For districts that used a computerized data tracking system (beginning in 2011), ANMs continued to maintain separate, paper-based reports for all services including FP and in this way continued to record SDM users. The Jharkhand MOHFW Director-in-Chief issued a special notification in 2011 to all 12 intervention districts to continue collecting data on SDM in paper format.
- *Provider training*: Pre-service training curricula for doctors and nurses were determined at the national level, and this meant that newly-trained doctors and nurses joining the health services in Jharkhand would have no knowledge of SDM. To fill this gap, IRH implemented a strong *in-service* training program and built capacity of MOHFW staff to conduct in-service training for their peers through the Contraceptive Technology Update trainings that included SDM. See also Section F.1.a.

<sup>17</sup> National Commission on Population – Population Policy <http://populationcommission.nic.in/npp.htm>.

As these examples indicate, the ability to vertically integrate (or institutionalize) SDM was affected by the method's absence from the national FP program. During the scale-up phase, IRH took many opportunities to advocate with the GOI MOHFW to integrate SDM, but GOI officials were not receptive and continued to request evidence and results of SDM's effectiveness and suitability. It became clear that the best way to advocate for SDM integration into the national FP program was to demonstrate its successful scale-up in Jharkhand.

### 5.2.2. Governmental instability

Within Jharkhand, political instability created challenges for scale-up.

- *Personnel turnover*: MOHFW leaders, including the Health Secretary and the NRHM Mission Director, turned over frequently; some officers were in place for less than a year. IRH promptly requested meetings with new leaders to build relationships, brief them on SDM, and garner their support.
- *Government changes*: Nine Chief Ministers were elected in Jharkhand in the past 11 years. The announcement of elections often put all government activities on hold for weeks at a time, and caused the suspension of scale-up activities.
- *Scandals*: A corruption scandal pertaining to procurement of health supplies reached as high as the Jharkhand Health Secretary, and the state MOHFW was subsequently reluctant to procure materials, including CycleBeads. To get around this, IRH donated CycleBeads for use in scale-up.
- *Insecurity*: Maoist rebels called Naxalites were active in Chatra, Khunti and Gumla districts (as well as several others not involved in scale-up). In a 2011 incident, Naxalites detained and interrogated two IRH staff at gun- and sword-point for nearly an hour in Khunti district. IRH often had to avoid certain areas and delay activities due to the safety threat the rebels posed.

### 5.2.3. Lack of non-public health networks

Beyond the MOHFW health system, few non-governmental health networks exist in Jharkhand, and even fewer engage in FP. While NGOs were active in many districts, their donor grants did not include money to participate in SDM scale-up. The many private providers in Jharkhand, including doctors and the traditional practitioners of the Indian System of Medicine, operated independently and did not have strong networks. Thus there was a lack of strong, independent organizations other than the government into which SDM services, training, technical leadership or advocacy could be integrated. IRH therefore focused on the MOHFW as the main user organization.

### 5.2.4. Access to Scale-Up Districts

Many scale-up districts were geographically isolated, and it was a challenge to travel to them from the state capital at Ranchi to provide technical assistance. This was an important reason IRH ultimately hired and based a District Coordinator in each district. Even within districts and blocks, many locations were difficult to access, causing challenges not only for IRH staff but for health workers trying to serve the population.

*"Pakur is a very poor district. No development agencies work here. Even government facilities are bad. Communication is a huge problem. It is a scattered, hilly, and rough area."*

*- MOHFW Program Manager, 2009*

### 5.3. Resource Organizations and the Resource Team

According to the ExpandNet model, a resource team is “the individuals and organizations that seek to promote and facilitate wider use of the innovation.”<sup>18</sup> A competent, qualified resource team is crucial to successful scale-up.

A primary objective of scale-up was for IRH to build the capacity of the Jharkhand MOHFW to serve as its own resource organization. To achieve this, it was important that key MOHFW personnel be involved in planning and implementing scale up from the beginning by effectively serving as part of the resource team. Important MOHFW personnel included the Health Secretary, the NRHM Mission Director, and the Reproductive and Child Health Officer, all based in Ranchi. District-level MOHFW leadership included the Civil Surgeon (the highest ranking health department staff in any district), the Assistant Chief Medical Officer (ACMO), and the District Program Manager.

	Primary	Secondary
Resource Organizations	IRH MOHFW (in training)	DSW Jhpiego Futures Group
User Organizations	MOHFW	DSW Population Council PSI

Table 9

While ACMOs’ portfolios included FP, they had many other priorities and were not able to devote the majority of their time to FP or SDM scale-up. Instead, IRH’s District Coordinators worked with district MOHFW leaders and with block-level Chief Medical Officers and Program Managers to schedule FP trainings in the district, coordinate IEC activities

including printing of IEC materials, and oversee other components such as collection of service statistics and inventory management for CycleBeads and other contraceptive supplies.

IRH held three state-level meetings at the MOHFW office in Ranchi over the course of the scale-up phase: one each in 2008, 2010, and 2013. These meetings were attended by MOHFW state leaders,<sup>19</sup> Civil Surgeons from the scale-up districts, representatives from other Government of Jharkhand ministries including the Department of Social Welfare (DSW), and representatives of entities managing USAID-funded development programs in Jharkhand, including Jhpiego and Futures Group.

These state-level partner meetings encouraged MOHFW ownership of, involvement in, and accountability for scale-up planning and management. Partner meetings afforded IRH and the MOHFW the opportunity to present the status of activities and M&E data. They enabled participants a chance to discuss the status of scale-up, reiterate the importance of a systems approach, and to troubleshoot and identify course corrections.

Meetings to plan and discuss scale-up were also held in each district. There was initially a lack of health advisory bodies at the district level, so IRH established a core committee in each of the first three districts to oversee the scale-up process. These committees included key district and block officials and met quarterly. Midway through the scale-up phase, the NRHM began to hold monthly review meetings in each district, so that special core committees were no longer required. IRH District Coordinators attended these meetings, which featured SDM as an occasional agenda item.

<sup>18</sup> Nine-step guide, page 7

<sup>19</sup> The Health Minister was not always present, but the NRHM Mission Director was.

Jhpiego, IntraHealth, and Futures Group participated actively in partner meetings at the state level. However, their projects were located outside of the SDM scale-up districts and did not include a focus on SDM. On occasion, SDM was integrated into training or communications materials with technical input from IRH, such as an interpersonal communication (IPC) toolkit on FP for CHW by Futures Group. However, this toolkit was not scaled up in the state by the government. Overall, because they were required to adhere to their own project benchmarks that did not include SDM, the effectiveness of other development partners in supporting SDM was limited. JHPEIGO under the MCHIP project developed CTU training materials that included SDM and conducted trainings in non-IRH intervention districts. However, no follow up was conducted after the trainings to explore if CycleBeads were needed or if SDM and LAM services were offered after initial trainings. The government led PPIUCD trainings in select districts, such as Koderma provided an opportunity to discuss the basket of contraceptive choices offered by the MOHFW, including SDM and LAM.

*“One health sub-centre covers about 35,000-40,000 population, and we have two ANMs at this sub-centre. To make matters worse, we only have one lady medical officer for 800,000 population.”*

*—MOHFW Program Manager, 2009*

After work began in the final six districts, the MOHFW asked IRH to expand its work, with the eventual goal of covering all 24 districts in Jharkhand. IRH had to decline this request, and instead focus its limited resources, staff, and funding, on ensuring sustainability in the 12 scale-up districts. This is an example of how, as the resource organization, IRH had to balance the requests of the MOHFW with strategic choices about how best to use available resources.

#### 5.4. User Organizations

According to the ExpandNet framework, a user organization is one that adopts and implements a health innovation<sup>20</sup>—in this case, SDM. Scale-up must build the institutional capacities of user organizations.

The primary user organization which integrated SDM was the **Jharkhand MOHFW**. The MOHFW represented an ideal user choice because its reach was unmatched. It operated a large network of health facilities that covered every district and block in the state, and had a new cadre of CHW called *sahiyya* with a presence in every village. Equally important, the MOHFW could set its own FP norms and policies (under the overall aegis of the central government) and had funding from NRHM for its FP program, increasing the likelihood that scale-up could be sustained. As stated, the strategy of the scale-up phase was to integrate SDM into the Jharkhand MOHFW’s FP services throughout the state, at both facility and community levels. This was preferable to launching a parallel and unsustainable structure; it would increase local ownership and use available resources in the most effective way.

Facility-based SDM scale-up focused on each level below the district hospital, from primary health centers to the sub-centers that served as peripheral outposts and provided rudimentary services. Personnel involved in SDM service delivery included medical officers (doctors), ANMs, and Lady Health Visitors (LHVs) who monitor the work of the ANMs. Health sub-centers are staffed by ANMs.

Because many people do not live close to a health center, *sahiyyas* are an important link to health services. FP was supposed to be included in their training, so *sahiyyas* in theory represented an opportunity to carry SDM to even the most remote locations. As of March 2012, however, *sahiyyas*

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<sup>20</sup> Nine-step guide, page 7.

had not been trained in FP and therefore not in SDM.<sup>21</sup> However, in the three initial scale-up districts, the Government of Jharkhand allocated funds for *sahiyya* training in SDM. After much delay, the state government developed a module for *sahiyyas* that included FP and SDM. Although the module was not printed until April 2013, training of trainers at six regional centers was conducted. IRH district coordinators attended and presented the SDM sessions. It is expected that training of *Sahiyyas* will roll out in the FY 2013- 2014.

The main advantage of working with the MOHFW was its status as the largest provider of health services in the state, reaching every district and every block; it therefore had the potential to reach a large number of people with SDM services and FP services in general. But Jharkhand was a relatively new state, and its health system needed strengthening. In reality, many health centers were understaffed and had a much larger catchment area than they could handle, with insufficient supervision and monitoring. *sahiyyas*

Factors affecting the MOH's capacity to offer SDM services included:

*Lack of priority on birth spacing:* Increasing rates of immunization and institutional births were major priorities for district health administrations. FP was not a priority, and when it was considered, it tended to be limited to female and male sterilization. This made it difficult to draw attention to the need to improve birth spacing services.

*"This is a very good method, since it is a natural method and has no side effects...Acceptability of the method among [the population] will be high. If the SDM is popularized here, its uptake will be very good as it will be suitable to most women."*

*–MOHFW district program manager, 2009*

*"The Government of India is not supporting any natural FP method. We are not sure about its reliability. It will demand a sustained counseling and training. Our workers do not have such time."*

*–Director of Family Welfare, Delhi, 2009*

*Lack of incentives for SDM integration:* Ironically, some GOI health schemes to achieve its population and RH goals may have disincentivized CHW from offering birth spacing methods. One such scheme encouraged women who delivered in a health facility, and to the CHW who referred them.<sup>22</sup> This had potential benefit for pregnant women, but meant that CHW had a greater incentive to avoid offering birth spacing methods to non-pregnant women because they stood to benefit financially when pregnancies occurred. In another scheme, women and men who obtained sterilizations received payment, with a referral fee to the health worker who brought them.

Meanwhile, health workers received no compensation for offering women non-permanent FP methods, even though it was part of their job.

In 2011, the GOI acted to correct this discrepancy and announced its plan to pilot the distribution of birth spacing oral contraceptives, condoms and emergency contraception by CHW; the latter would keep a small fee for services. Some of the pilot districts overlapped with SDM scale-up districts. However, it was unclear how CycleBeads would be affected since they were not in the national FP program. No data from such sales has been reported/ collated yet at the district level.]

*Attitudes of providers and leaders towards SDM:* IRH conducted stakeholder interviews at the beginning of the scale-up phase to understand the perceptions of MOHFW staff and policymakers regarding integration of fertility awareness-based methods into the FP program.<sup>23</sup> Most stakeholders, particularly those at the district level, expressed positive opinions. In general,

<sup>21</sup> Prior to their formal FP training, *sahiyyas* were able to make referrals for sterilization and IUDs; they received a financial incentive for each referral made.

<sup>22</sup> See Lancet article: [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)60744-1/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60744-1/fulltext)

<sup>23</sup> Source: Integration and Scaling-Up FAM in India: Findings from a Stakeholders Study. Institute for Reproductive Health, 2010.

district-level MOHFW managers, providers and CHW felt that a natural method with no side effects, like SDM, would be acceptable and particularly useful for newly married couples. State-level officials also expressed support for SDM integration. In contrast, national officials did not support integration, and expressed misperceptions about SDM’s efficacy, doubts about the feasibility of integrating and offering SDM, and concerns regarding the training time it would require. Endline stakeholder interviews suggest that the GOI became somewhat more supportive of SDM, but that advocacy was still needed at the national level.

Integrated Child Development Services (ICDS) is a centrally funded program managed by Jharkhand’s Department of Social Welfare (DSW). ICDS maintains a cadre of community health workers called Anganwadi workers (AWW) who engage primarily in maternal and child health and nutrition activities. Although the Jharkhand DSW did not commit to being involved in SDM scale-up, AWWs and their supervisors from some of the scale-up districts attended MOH-sponsored trainings on SDM and LAM. Due to the AWW’s focus on child health, they have been involved mostly in LAM counseling rather than SDM. ICDS-3 ended in 2010, and since the focus of ICDS-4 is to increase nutrition efforts as rather than family planning, it is unclear if LAM will be a part of AWW’s work going forward.

## 6. Continued Analysis of ExpandNet Elements: Strategic Choice Areas

The ExpandNet Model lists four areas in which strategic choices around scale-up must be made: **organizational process, dissemination and advocacy, M& E, and costs/resource mobilization**. These strategic choice areas apply to both vertical and horizontal scale-up. Table 5 provides a snapshot of the most important strategic choices that IRH made in pursuit of both vertical and horizontal scale-up in Jharkhand. Subsequent sections will discuss strategic choices in more detail.

Table 10: Strategic choices for vertical and horizontal scale-up in MOHFW system

Strategic choice area	Vertical scale-up	Horizontal scale-up
<b>Organizational process</b>	<ul style="list-style-type: none"> <li>MOHFW was primary user organization due to size, reach, influence</li> <li>IRH office was located in MOHFW building to promote collaboration</li> <li>Focused on health systems strengthening, not only SDM integration</li> <li>Participatory, as all meetings were convened by MOHFW (not IRH)</li> </ul>	<ul style="list-style-type: none"> <li>Participatory, as MOHFW decided which districts would scale up</li> <li>Pace was gradual, as scale-up started with three districts and three were added each year.</li> <li>IRH and MOHFW collaborated to schedule planning meetings, develop training schedules, etc.</li> <li>Training MOHFW staff as trainers to build capacity and support sustainability</li> <li>Simplification of training modules to enhance replicability</li> </ul>
<b>Dissemination and advocacy</b>	<ul style="list-style-type: none"> <li>Intensive advocacy through one-on-one meetings and relationship building with state MOHFW leaders</li> <li>Orientation/advocacy meetings and presentations with state and district MOHFW leadership and development partners</li> </ul>	<ul style="list-style-type: none"> <li>One-on-one meetings and relationship building with district leaders</li> <li>Core committee meetings in districts oversaw scale-up and fostered local ownership</li> <li>Involving development partners from other districts in partner meetings to</li> </ul>

	<ul style="list-style-type: none"> <li>• Efforts to have SDM included in state FP policy norms, budget lines, procurement plans, IEC, reporting systems, etc.</li> </ul>	encourage them to integrate SDM
<b>M&amp;E</b>	<ul style="list-style-type: none"> <li>• IRH developed and tracked scale-up benchmarks</li> </ul>	<ul style="list-style-type: none"> <li>• Service statistics tracking</li> <li>• SDP assessment</li> <li>• KIT</li> <li>• CFU</li> <li>• Pre and post tests for CTUs</li> <li>• Household surveys</li> <li>• Stakeholder interviews</li> </ul>
<b>Resource mobilization</b>	<ul style="list-style-type: none"> <li>• Scale-up activities (such as training) funded by MOHFW (not by IRH) to foster ownership and sustainability; MOHFW committed funds via an MOU with IRH</li> <li>• Budgets for activities such as training &amp; IEC allocated at state level</li> <li>• IRH facilitated MOH’s CycleBeads procurement process at state level</li> </ul>	<ul style="list-style-type: none"> <li>• Funds released for scale-up activities from state to districts</li> </ul>

## 6.1. Capacity Building and Technical Assistance

IRH worked in a various ways to build the capacity of the MOHFW to offer SDM services and to improve the overall strength of the FP program. This section discusses the challenges and opportunities the resource organization faced, key decisions made about capacity building, and the reasoning behind those decisions.

### 6.1.1. In-Service Training and Supervision

Developing MOHFW staff to serve as master trainers was a strategy to build in-house capacity, strengthen the health system, and ensure sustainability of SDM within the user organization. IRH used a cascade-training approach combined with mentoring and monitoring to ensure quality. IRH trained MOHFW staff from each district to conduct CTU trainings (CTUs developed by IRH included all FP methods). IRH District Coordinators then mentored these master trainers while they trained at the block level, ultimately doing so in about half of block trainings. Because there were no dedicated government trainers, master trainers were typically medical officers with no training experience.

For all trainings, IRH’s District Coordinators worked with district and block authorities to develop the training schedules. IRH shared the SDM curriculum and participant handouts (comic books) with the MOHFW for printing and use during the trainings. As noted, the SDM curriculum was streamlined between the introductory and the scale-up phases to fit in a two-hour time frame.

It is notable that the MOHFW asked IRH to conduct full CTUs—not only the SDM portion--for medical officers and ANMs in each of the 12 scale-up districts and in six additional districts. This demonstrated that the MOHFW perceived IRH to be a credible FP technical assistance organization, and not a niche organization focusing on a single method.

Trainings during the scale-up phase were paid for with government funds, with the exception of IRH staff time and travel. IRH also supported at least two refresher trainings for master trainers at the state level. During scale-up, IRH-trained MOHFW staff conducted most of the provider trainings. IRH staff, however, did most training for top district leaders.

It was not possible to conduct SDM refresher trainings for most service providers, however, due to the large number of health workers involved. Government funding was limited, and other trainings (such as neonatal health care, immunization, and Vitamin A) were fully funded by donors and competed for the time of health workers.

As of March 2013, approximately 11,793 service providers were trained on SDM. Almost all (87%) were female. Thirty percent of trained providers were facility-based, while the remainder were community health workers. During most of the scale-up phase, *sahiyyas* were not trained in FP because their official FP curriculum was still under development. The government made an exception in the first three scale-up districts, however, and allowed *sahiyyas* to be trained in SDM.

The primary tool for verifying the knowledge and skills of trained providers was the **KIT**, a two-page checklist used while observing a demonstration counseling session. KIT (which IRH also used in other scale-up countries) provided a way to monitor SDM counseling among trained providers at facility and community levels. IRH District Coordinators visited a sample of providers three and nine months after training to administer the KIT. Results were shared with Jharkhand MOHFW and used to make programmatic decisions and adjustments.

As expected, KIT data from the first three scale-up districts revealed a lower level of knowledge and competence than in the introductory phase. This reflected the shorter training time, and training by relatively inexperienced trainers. IRH had to accept that provider knowledge would not be the same as in the highly-controlled environment of the introductory phase, and to emphasize essential knowledge and skills.

IRH used district and block comparisons to identify areas where focused technical assistance from District Coordinators was required. (See Figure 5 at left for an example of how KIT data was compared across districts.) In many cases, knowledge levels of key counseling points ranged between 45 and 95 percent three months after training. Significant improvements were observed when the KIT was reapplied nine months after training (See Figure 5 for an example).

It was also important to ensure that clients who had chosen SDM were using it correctly. This was an important measure of service quality. For this purpose, IRH developed a **CFU** form to gather information on knowledge, method use, spousal communication, and satisfaction among clients. The one-page form was generally applied in conjunction with the KIT: that is, providers who completed the KIT would then administer the CFU to no more than five of their SDM clients, in the presence of the IRH District Coordinator.

Results from CFU were satisfactory in most areas: 80 to 90 percent of SDM users were using the method correctly. Usually, clients with incorrect knowledge could be traced to providers with incorrect knowledge and who therefore could be mentored to improve their counseling.

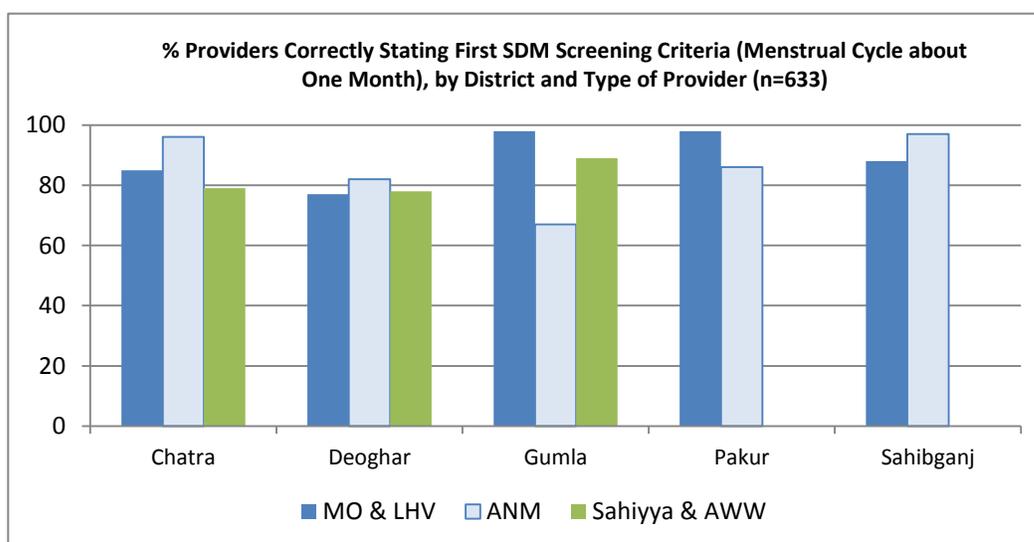


Figure 5: % Providers Correctly Stating First SDM Screening Criteria (Menstrual Cycle about One Month), by District and Type of Provider (n=633)

Table 11: % of Clients Who Responded Correctly to CFU Questions in Five Districts (n=350)

Criteria:	<i>Cycle start date is marked on calendar</i>	<i>Black band is on the correct bead</i>	<i>Correct demonstration by user</i>
<b>District:</b>			
<b>Chatra</b>	92	100	90
<b>Deoghar</b>	90	98	91
<b>Gumla</b>	89	99	95
<b>Pakur</b>	95	100	93
<b>Sahibgunj</b>	82	97	80
<b>Average</b>	<b>89.6</b>	<b>98.8</b>	<b>89.8</b>

### 6.1.2. Engaging Institutions within the Educational System (Pre-Service Training)

IRH did not integrate SDM into pre-service training in Jharkhand for several reasons. The challenges for doctor and nurse training included (a) medical and nursing school curricula were determined at the central level, where support for SDM was negligible and SDM was not present in existing curricula or textbooks; and (b) while individual instructors in Jharkhand had the ability to adapt their curricula, many health workers were trained outside the state. IRH advocated with GOI authorities in Delhi to integrate SDM into the national FP program and health education curricula, contributing articles to national nursing journals, and communicating with textbook authors regarding SDM inclusion in upcoming revisions.

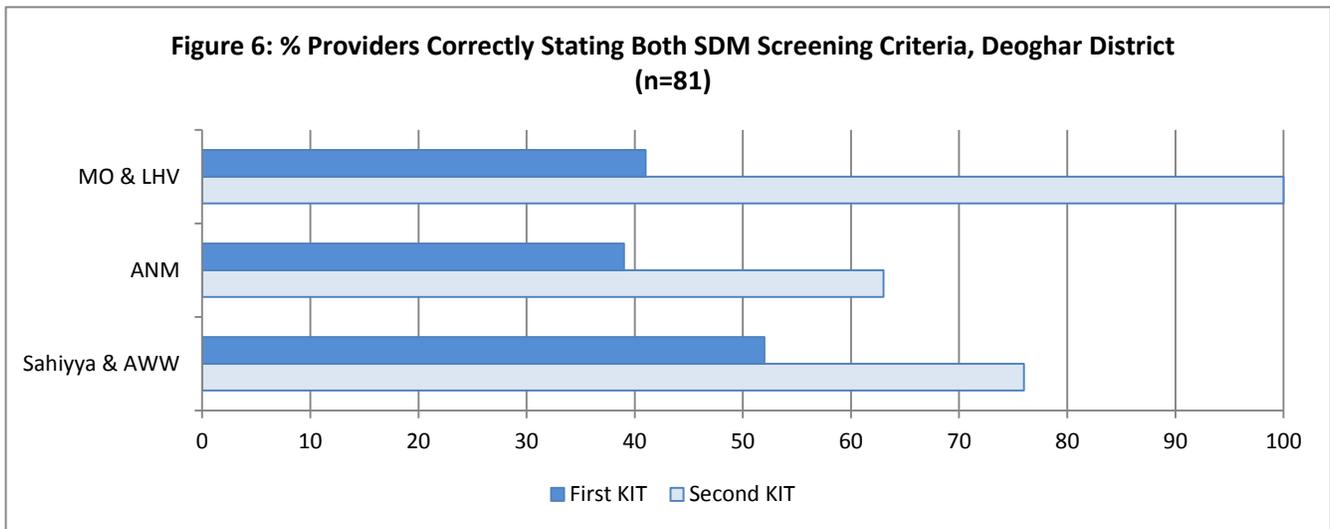


Figure 6: % Providers Correctly Stating Both SDM Screening Criteria, Deoghar District (n=81)

During the scale-up phase, a USAID-funded project was working to improve ANM training centres in three districts of Jharkhand. (These did not overlap with scale-up districts, but ANMs typically move to other districts once they are trained.) This project developed a training manual for ANMs, and the FP section included SDM. Although IRH contacted the project’s management and USAID to arrange for technical review of the manual’s SDM section, the manual was printed without IRH’s input, and it contained incorrect information about SDM. IRH gave the project corrected pages to insert in the manual. Still, this was a missed opportunity for accurate training on SDM for ANMs in Jharkhand, and reflected the general lack of collaboration among organizations working in Jharkhand and, more specifically, IRH’s lack of control over materials created by others.

As noted, the state government was developing training modules for sahiyyas. This long-delayed module, which included FP methods, had been in the pipeline since 2008. IRH provided information on SDM for inclusion, and made every effort to follow up with the module’s authors to ensure that SDM would in fact be included. The module, which does include SDM, was released in December 2012 printed in April 2013. Six training of trainers sessions took place, and IRH district coordinators taught the sessions on SDM. It is expected that the training of Sahiyyas will roll out in the fiscal year 2013- 2014.

### 6.1.3. Other TA to Build Workforce Capacity

For SDM integration to be successful, it was necessary to strengthen the health system as a whole, and this went beyond health worker training. Data from the midline SDP assessment revealed that contraceptive stock outs (including but not limited to CycleBeads) were a common problem. IRH district coordinators worked with program managers to improve inventory tracking to prevent stock-outs.

IRH also worked with the MOHFW’s IEC unit to develop job aids to assist ANMs provision of *all* FP methods. One set of job aids was for permanent methods, and the other on birth spacing methods including SDM. The IEC materials were distributed for use in all 24 of Jharkhand’s districts. This collaboration, requested by the government, was an important step towards institutionalization of SDM in the service delivery package.

Another arena in which IRH built capacity within the Jharkhand MOHFW was interpreting FP data. MOHFW officials did not regularly analyze FP statistics because FP had not been a priority. Additionally, some bureaucrats who transferred into MOHFW leadership positions did not have a public health background. IRH tabulated the service statistics data collected by the MOHFW on all methods, to monitor changes in the FP program’s progress over time. In this way, IRH helped build capacity for evidence-based programming and planning. See Section F.4.

#### 6.1.4. Changing IRH Staff Capacity to Support Scale-Up

*District Coordinator tasks included:*

- ✓ advocate for FP service delivery improvements (including SDM integration);
- ✓ facilitate meetings to plan and review progress towards scale-up;
- ✓ train a pool of MOHFW trainers to conduct provider trainings;
- ✓ mentor and monitor trainings;
- ✓ conduct quality assurance activities with MOHFW staff including follow-up with providers and clients through KIT and Client Follow-up; and
- ✓ provide technical assistance to the MOHFW in areas such as management of contraceptive commodities.

Scale-up work in India was directed by IRH’s Country Representative based in Delhi. She was initially supported only by an Operations Associate who contributed to financial and administrative management of all IRH work in India.<sup>24</sup> IRH staff in Delhi grew to include a Quality Assurance Manager (M&E, research), Program Manager, Communications Officer and Program Associate. All these positions provided support to the Jharkhand work, and also had responsibilities outside of Jharkhand. The Country Representative and other Delhi-based staff made frequent trips to Jharkhand throughout scale-up to meet with state officials and development partners, provide technical assistance such as trainings for high-level officials, oversee M&E and guide IRH Jharkhand staff .

State-level IRH staff, based in the Jharkhand’s capital of Ranchi, were the State Program Officer and a Program Associate. The State Program Officer oversaw all state-

based activities (under the direction of the Country Representative) and coordinated and advocated with the MOHFW to ensure necessary approvals, support and participation. The State Program Officer also conducted orientation meetings and master trainings in the first three scale-up districts.

IRH quickly realized that, without a consistent presence in the districts, scale-up could not progress as planned. Periodic visits by the State Program Officer to hold orientations and trainings were insufficient to move integration forward at a good pace. Capacity building in each district involved ongoing presence in the district – not just to ensure all health workers were trained, but to ensure that they were offering and keeping track of users; that quality was good and clients could use the method correctly; and that clinics and *sahiyyas* had CycleBeads. IRH therefore hired a District Coordinator as work came online in each district, for an eventual total of 12, and an additional Program Associate at Ranchi.

At the onset of scale-up, the Population Council seconded a full-time staff person to IRH’s office in Ranchi to oversee M&E through a sub agreement with IRH. The Population Council managed the researchers hired to conduct the baseline household survey and stakeholder interviews. After the baseline was completed, there was not enough work in Jharkhand to justify a full-time M&E specialist. Therefore, IRH ended its partnership with Population Council in December 2009. Subsequent research and M&E activities in Jharkhand were overseen by IRH’s Delhi-based Quality Assurance Manager, who made frequent trips to Jharkhand.

## 6.2. Dissemination, Awareness-Raising and Demand Creation

### 6.2.1. What Was Done to Create Awareness and Demand

IRH worked with the MOHFW to raise awareness of and create demand for SDM and other FP methods in a variety of ways. IRH provided prototypes of IEC posters and pamphlets that MOHFW printed and distributed in primary health centers and health sub-centers. When the MOHFW's limited printing budget ran out, IRH paid for additional printing. IRH contracted large outdoor wall paintings at SDPs that depicted SDM and other methods. *Sahiyyas* conducted community education through interpersonal communication and group talks.

Beginning in 2010, the Jharkhand MOHFW transformed World Population Day into a month-long occasion to raise awareness about FP methods, including SDM. It organized events and offered services in every district. IRH provided prototypes for FP billboards and posters, and SDM information was included in most of the IEC efforts. As SDM services were offered in only 12 of Jharkhand's 24 districts, the MOHFW to provide a distinct set of communications materials for the districts where SDM was included, though creating and distributing two sets of communications materials presented a logistical challenge.

To reach a broader audience through an innovative demand creation strategy, IRH hired a radio production company to produce a community radio program in Gumla district. The company and a group of community radio jockeys produced 10 episodes containing dialogue and songs about FP—including SDM—written and performed by local citizens. The episodes were broadcast throughout Gumla and narrowcast at several locations in the district after that. The community radio jockeys also spoke about the methods within their communities. While the radio programs were well received, it was difficult to isolate their effect from that of other strategies used to generate demand. The radio programs were a test case, and IRH intended to show the Jharkhand government that such an activity was a good use of IEC resources: the state had funds for community radio programs, but did not use them. While IRH shared its experiences, follow up efforts were not fruitful. IRH engaged in a varie

IRH also supported social marketing and diffusion efforts. Box X provides more details on a pilot undertaken in partnership with Population Services International (PSI) to socially market CycleBeads. To promote social diffusion through interpersonal communication, ANMs and *sahiyyas* included SDM in their community education initiatives and group health talks.

As discussed in Section C.3, results of the Endline Survey indicated that the IEC and social diffusion efforts undertaken by IRH and partners were successful in raising awareness of and creating demand for SDM. In the 2009 Baseline Survey, only 2.5% of women and 2.7% of men surveyed had heard of SDM; by the 2013 Endline Survey these numbers had increased to 49.1 and 47.1%, respectively. SDM users accounted for 0.60% of FP users at Baseline, which increased to 6.0% of FP users at endline.

### ***Social Marketing of CycleBeads***

While the Jharkhand MOHFW was the primary focus of the scale-up phase, IRH simultaneously pursued opportunities to expand access to SDM through other channels to reach people who were not served by or who chose not to access services from public sector entities.

In 2010, IRH provided Population Services International (PSI) funding to pilot social marketing of CycleBeads in Deoghar district. This involved repackaging CycleBeads, and rebranding them as *Suruksha Mala*. It also involved a new service delivery strategy: rather than be dispensed at no cost by health workers, *Suruksha Mala* were sold for about 32 rupees (approximately \$0.70) by PSI community-based workers (female ‘Interpersonal Communicators’) who educated people about the method via community talks.

A total of 3,907 sets of *Suruksha Mala* were sold in eight blocks of Deoghar district as a result of PSI’s intervention, along with socially marketed condoms and oral contraceptives.

PSI cited the remote nature of the villages and lack of availability of local transport as factors that negatively affected Interpersonal Communicators’ ability to reach the target population.

### ***6.2.2. Constraints on demand creation***

Demand creation activities were challenging for a variety of reasons. The general scale-up strategy was to integrate SDM into existing systems. While the MOHFW had an IEC working group in name, it was inactive. Essentially, with the exception of World Population Month, the MOHFW did not engage in any large-scale FP IEC efforts into which SDM could be integrated during the scale-up phase.

Typically, efforts to introduce or promote an FP method or FP are accompanied by a mass-media campaign. To take one recent example, the USAID-funded DIMPA Project promoted injectable contraceptives in private sector services, and hired a large media conglomerate to design extensive, multi-channel campaigns in more than 45 cities in three states. IRH’s limited scope, and the lack of IEC activity within the MOHFW, meant it could not emulate such an endeavor on behalf of SDM. Rather, it focused on primarily on the budget-conscious IEC efforts noted above and making services available.

*“There is 11 percent unmet need for birth spacing. When you give choices, condoms and pills have a much earlier start than the beads. People don’t know about the efficacy of the beads. For that you will need to go out with a huge communication campaign focusing on SDM.”*

*–technical assistance agency, Jharkhand, 2009*

### 6.3. Advocacy for SDM Integration and Scale-Up: Successes and Failures

IRH initiated SDM scale-up at the request of the Jharkhand MOHFW, but frequent turnover of

*“The situation is that I meet with the Deputy Commissioner, the District Program Officer and the Civil Surgeon. All three have considered that this program is most useful for our family planning, and [they say], ‘We will cooperate with you and include this program with other methods of family planning.’ Whenever I approach them, they agree to whatever we ask. But whenever I’m not there, they’re not thinking about it. But I think they will get ownership if the work continues over time through me and IRH.”*

–IRH District Coordinator, 2009

*“At the organizational level of the Ministry of Health, they see value added in our programs. Whatever barriers we are facing are more at individual levels. While they’re figuring out ways to integrate, they do require a lot of facilitation from us. We are not yet at a level where we can say that thinking about SDM comes naturally to them.”*

–IRH Country Representative, 2009

officials resulted in a lack of institutional memory within the ministry. Constant advocacy with MOHFW at many levels was an essential part of scale-up to ensure its ongoing commitment to the process and see it they followed through on actions to achieve institutionalization of SDM. IRH’s work in various districts and the significant evidence base it built – during both the introductory and scale up phases – led the MOHFW to perceive it as a credible advocate.

Much of IRH’s advocacy took the form of one-on-one meetings and phone calls with MOHFW officials to communicate the evidence behind the work, and to request specific actions to move scale-up forward, such as including SDM training and IEC in annual budgets, sending directives to districts on scale-up activities, and procuring CycleBeads.

Staff turnover included the Health Secretary, NRHM Mission Director, and other leadership positions; IRH met with new officials as soon as they arrived to orient them on SDM scale-up to ensure their support.

Persistence was crucial, as it was not always easy to secure meetings with government officials who had many other interests competing for their attention. Taking advantage of unplanned opportunities also was important: in certain cases, project advances resulted from chance encounters with MOHFW officials at an airport.

While the various leaders were committed to SDM scale-up to different degrees, none were opposed. Proactive, frequent communications on the part of IRH ensured ongoing support for the scale-up process. Had IRH not met with key leaders consistently, integration would not have progressed nearly as rapidly, if at all.

Advocacy with state-level MOHFW leaders had to be carried out by IRH’s Delhi-based Country Representative. The IRH staff based in Jharkhand were locals and did not carry enough clout to be granted meetings with senior MOHFW officials. This meant that the Country Representative travelled to Ranchi eight to ten times per year.

Regular district meetings with MOHFW leaders were important. Once IRH hired District Coordinators, these staff did the bulk of advocacy in the districts, although IRH’s State Program Officer and Country Representative also met with district officials during occasional field visits and when these officials travelled to Ranchi for state-level partners meetings.

As an example of the importance of obtaining district-level buy-in, IRH’s Country Representative made frequent visits to Gumla, often bringing international visitors (such as those from Washington, DC) because of the district’s proximity to Ranchi. These visits helped to impress upon district leadership the importance of SDM scale-up. Later, the ACMO of Gumla (the second-highest MOHFW official in the district) was transferred to Hazaribagh, one of the new districts. The fact that

he was already very supportive of SDM meant scale-up advanced more quickly there than in other new districts.

Another venue for advocacy was partners' meetings. As noted in Section E.3, the MOHFW hosted three state-level partners meetings over the course of scale-up, during which IRH shared the status of scale-up and results from M&E activities. The meetings were attended by state and district MOHFW leaders and other development partners working in the state. The meetings served as a forum for project planning and review, kept stakeholders involved in the planning process and provided a venue for IRH to showcase achievements and reiterate the importance of SDM scale-up. Scheduling the partners meetings was a joint effort between IRH and MOHFW. Invitations were sent by the MOH, on MOHFW letterhead, rather than by IRH. This was important in order to demonstrate MOHFW ownership and to ensure that all district civil surgeons (the highest district-based officials) would heed the invitation.

#### Advocacy Success: State government investment in scale-up

Perhaps IRH's greatest advocacy success was when it and the Jharkhand MOHFW signed an MOU in which the government committed to investing more than \$200,000 to SDM scale up. This was a symbol not only of the government's commitment to the scale-up process, but of their appreciation of the work IRH had done on their behalf to that point, and IRH's tenacity in getting their commitment in writing. Even so, IRH had to continue to advocate with the MOHFW to ensure the funds were released and to continue to build the relationship.

#### Advocacy Success: CycleBeads Manufacture:

Another main target of IRH advocacy was HLL Lifecare Limited, the largest contraceptive manufacturer in India and a GOI enterprise. HLL deals in private sector sales, and it sells contraceptives to the central government, which supplies contraceptives to Jharkhand.

It was important to Indian stakeholders that CycleBeads be manufactured in-country. In the introductory phase, a small company in Mumbai (My Life Cycle) became a licensed manufacturer of CycleBeads, but it was evident that it did not have capacity to produce and distribute the large quantities of CycleBeads that would be required for the scale-up phase. Also, Jharkhand officials said it would be difficult to obtain procurement approval for a virtually unknown entity such as My Life Cycle. IRH therefore contacted HLL as the scale-up phase was being planned.

To get HLL to agree and to enter into a sublicensing agreement with Cycle Technologies, the U.S.-based corporation that holds the manufacturing license for CycleBeads, IRH engaged in advocacy efforts that included relationship-building with key HLL staff; ongoing communications; travel to HLL's headquarters in Trivandrum with a Cycle Technologies representative to make presentations; and a day-long meeting in Delhi with HLL, USAID, and Abt Associates to discuss CycleBeads' potential in India and persuade HLL that it would benefit from the manufacture and sale of CycleBeads. In December 2009, HLL signed an agreement to become an authorized CycleBeads manufacturer, and in July 2011, signed another with Cycle Technologies that licensed HLL to rebrand the product for social marketing and private-sector sales.

#### Advocacy Failure: CycleBeads Procurement

Once the sub-licensing agreement was in place, IRH facilitated in-person meetings between HLL representatives to negotiate a purchase. In 2010, the Jharkhand MOHFW and HLL neared a purchase agreement, but procurement was put on hold due to national elections. This was followed by a scandal in which senior Jharkhand officials were accused of accepting kickbacks in exchange

for procurements. The ramifications of this scandal lingered, and procurement remained an extremely sensitive topic in Jharkhand for the duration of the scale-up phase. Consequently, IRH had to cease advocating for state-level procurement of CycleBeads and instead turned to other options, such as facilitating district-level requests where a strong case could be built for the need for procurement. Ultimately, neither the state nor districts procured CycleBeads.

Since the funds for NRHM are approved by the central level, the funds requested for CycleBeads procurement in 2009- 2010 were turned down because SDM is not yet part of the national program. Subsequently, the GoJ did not include in their planning the procurement of CycleBeads.

IRH donated CycleBeads for use in scale-up so that work could proceed in spite of procurement delays and later procured 100,000 sets of CycleBeads for the Jharkhand MOHFW as part of the turnover process. IRH assisted the MOHFW in creating a distribution plan to ensure that CycleBeads would be available in the 12 scale-up districts, and to support scale-up to the remaining 12. There have been small requests for CycleBeads from organizations such as Population Council and World Vision but the cost of the product locally has been a deterrent as they lack the funds to procure this product.

#### Advocacy Failure: National Institutionalization of SDM

The Jharkhand MOHFW was interested in and able to take action to integrate SDM into its FP program. Yet the GOI and its MOHFW never arrived at the same level of acceptance, despite IRH advocacy.

SDM was included in several key national documents in 2005, yet it was not made part of India's national FP program. Scale-up proceeded in Jharkhand in spite of this, but would have been greatly facilitated had the GOI supported the expansion of the method, and particularly if SDM been part the national FP program. GOI support would have facilitated CycleBeads procurement and M&E, and earned the buy-in of state and district MOHFW officials for SDM scale-up.

IRH met several times with GOI officials in the first few years of scale-up to advocate for the inclusion of SDM in the national FP program. However, the officials believed that SDM integration would not be cost effective compared with long-acting methods such as the IUD.

Because of the GOI's lack of interest, IRH focused on Jharkhand. The underlying strategy was that positive outcomes in Jharkhand would compel the GOI to reconsider the contribution SDM could make to its national FP goals. By the fifth and sixth years of scale-up (2012-2013), IRH initiated more focused advocacy with the GOI to showcase achievements to date. Scale-up findings were shared in two national meetings in 2012 and 2013. GOI officials responded positively to these findings, but wanted to see endline results before to deciding on a further course of action. However, the GOI's focus is on consolidating FP methods that are already present in its program but underused, such as oral contraceptive pills and IUDs; it is uncertain whether officials will be willing to shift this focus and include SDM in the national program in the future.

#### 6.4. Monitoring SDM Scale-Up

Collecting, analyzing, and summarizing M&E data was essential, both for troubleshooting areas that needed more attention and communicating successes. Measuring scale-up required examining and monitoring several factors simultaneously:

- Expansion and increasing coverage of the innovation (horizontal scale-up)

- Incorporating the innovation into sustainable systems within user and resource organizations (vertical scale-up)
- Maintaining the innovation’s quality during both horizontal and vertical scale-up

Most of the M&E benchmarks, indicators and data were discussed in Sections C and D.

IRH did not limit its M&E to SDM. When possible, data pertaining to other methods were collected, both to understand the impact of SDM integration on the FP program as a whole, and to examine quality issues and improve services across all methods.

M&E was participatory and transparent. IRH shared intermediate results with the resource team and at partners meetings so that MOHFW could provide direction, and IRH and MOHFW could jointly make improvements. IRH also met with district leaders to review data.

An example of data use is collection and analysis of service statistics. IRH tracked service statistics for all methods to ensure that offering SDM would not adversely impact uptake of other FP methods; to demonstrate the potential need in the community for SDM when offered as part of informed choice; and to identify health facilities that needed more supportive supervision.

IRH collected block- and district-level statistics on FP method uptake from district headquarters monthly, and analyzed and graphed them using Excel-based software. IRH then met monthly with the district Program Manager, Civil Surgeon, and Medical Officer in Charge of a particular block to discuss results and seek the causes of any positive or negative outcome. This was an opportunity to identify and address issues such as training, stocks, record keeping, and service quality at particular SDPs. Figure 9 provides an example of statistics collected in Gumla for the April 2010-January 2011 period.

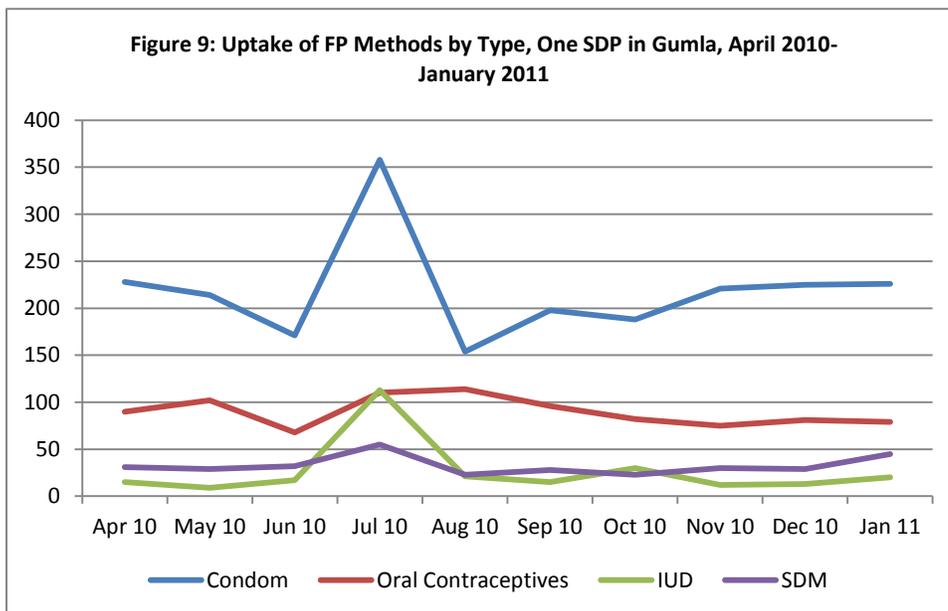


Figure 7: Uptake of FP Methods by Type, One SDP in Gumla, April 2010-January 2011

IRH also combined data components to gain more insight into what was happening in each block. For example, IRH compared providers’ CTU post-test scores in a given block with the block’s service statistics to determine correlations. By engaging MOHFW leaders at state and district levels in the

regular review of M&E data in partners meetings and one-on-one meetings, IRH built the capacity of MOHFW staff to conduct regular monitoring and use data for programmatic adjustments. Finally, IRH also used data to inform internal management. The data provided insight into what was working well and what needed attention, and enabled IRH leadership to better manage the District Coordinators' work.

## 6.5. Resource Mobilization

Scale-up requires significant financial investments in training, demand-generation activities, supplies (CycleBeads), IEC materials, travel, research agencies and other components. IRH received funding from USAID, but scaling up SDM services to approximately 12 million people required additional resources. It was therefore essential to leverage funds.

One reason that IRH chose the Jharkhand MOHFW as the main user organization was because it had funds to implement scale-up and to sustain services after IRH's formal role was over. The MOHFW contributed enormous resources to scale-up. It covered the costs of SDM and CTU trainings for MOHFW staff. It also paid for printing of training curricula and comic books, IEC materials, and World Population Day billboards which included information on SDM. Finally, the MOHFW provided office space to IRH in Ranchi at no cost.

Making its own investments in the SDM scale-up gave MOHFW leaders a stake in its success and motivated them to ensure that the activities flourished. Fostering ownership was a reason that IRH pushed for the MOU with the MOHFW in which it put its financial commitment in writing, and that IRH continued to advocate to ensure that the MOHFW abided by its financial commitment.

The latter was not always easy, and IRH had to balance the need for the government to make its own investments with the need to proceed in a timely fashion. The first three scale-up districts were selected in the fall of 2007, yet provider trainings only began in June 2008 because the MOHFW did not release funds until that time. IRH was torn between letting so much time pass without starting the trainings (in part because it was accountable to the donor to achieve yearly benchmarks) and paying for the initial round of training, which it could afford to do but which would set a precedent that would jeopardize sustainability and local ownership of the scale-up effort. Because the MOHFW had funds to pay for the trainings, IRH waited and continued to build its relationship with the MOHFW at the state level. The MOHFW eventually released the funds and proceeded to pay for all subsequent trainings for its staff. This enabled IRH to use its own funds in ways that maximized its strategic advantage as a technical assistance organization, such as materials design, M&E and quality assurance.

The MOHFW had been accustomed to donor-funded projects that covered all training expenses. In contrast, IRH built a close relationship with MOHFW and persuaded it to fund its own trainings over a large geographic area. With IRH's assistance, the Jharkhand MOHFW included SDM training in its budget request to the GOI for CTUs.

IRH also worked with district leaders to strategize whether the districts' own funds could contribute to scale-up activities. For example, when it became clear that CycleBeads would not be procured at the state level, IRH engaged in conversations in several districts to determine if the latter's discretionary funds could be used to purchase CycleBeads. No further action occurred, even though some districts expressed the need to procure directly.

## Conclusions

### 1. Key Elements that Facilitated SDM Scale-Up

#### 1.1. Utility of the ExpandNet framework

In part due to the fluid nature of the scale-up process, the ExpandNet framework was a useful tool in planning for and conceptualizing scale-up by the resource team. In particular, the values of systems thinking, scalability, sustainability, and attention to human rights were guideposts for planning and strategic decision-making. As stipulated in the ExpandNet model, the effective use of M&E data was essential for making improvements and for building and maintaining a shared vision of scale-up on the part of key stakeholders.

In the Jharkhand context, making strategic choices was not always straightforward. The environment was constantly shifting due to factors beyond IRH control; it was difficult to predict the future and what might work or not work, or even to schedule events very far in advance. While the innovation was evidence-based, the process of scale-up at times required decision-making based on intuition. In this way, the Jharkhand experience confirmed the view of ExpandNet that the scale-up process is as much an art as a science. It required a wide skill set on the part of the resource team – from handling delicate interpersonal relations with finesse, to project management, to data analysis – and the ability to adapt quickly to a changing environment. It also required a high degree of leadership, commitment, and collaboration from the MOHFW.

#### 1.2. Partner choices of utmost importance

ExpandNet says that when embarking on scale-up, one should ‘begin with the end in mind.’ For this reason, in spite of the many challenges, working with the Jharkhand MOHFW was the right choice. Not only was it the largest FP service delivery organization in the state, but it had its own funds with which it could continue SDM service delivery and training after IRH’s involvement ended. In addition, the Government of Jharkhand’s experiences may have the potential to influence decision-making within the GOI (and other important stakeholders), and therefore success in Jharkhand could contribute to the ultimate goal of SDM integration into the national FP program.

An advantage to working primarily with the government was that the hierarchical nature of the health system facilitated scale-up efforts. All the directives for the scale up process – including the addition of new scale-up districts, the scheduling of state level partners meetings, and the disbursement of funds for district and block-level trainings and IEC activities – came from the state MOHFW office in Ranchi to the districts, which had to abide by these directives. Therefore, while it was important for IRH to engage in orientations, advocacy and relationship building in each scale-up district, all districts were held accountable by the state to integrate SDM into their services. Importantly, districts have flexibility in how they use some of their funds, which was an advantage during scale-up.

#### 1.3. Reputation, or how you work, is as important as what you do:

From the earliest days of the scale-up phase, IRH actively sought opportunities to hold orientation meetings and trainings, even in the most distant corners of Jharkhand state where other organizations did not wish to work. This fostered a considerable amount of credibility, respect and good will on the part of the MOHFW. Pakur district, for example, was among the most remote. Accommodations were poor, and many areas had no plumbing or electricity. Still, IRH’s State Program Officer held orientations and trainings there, and later a full program was launched and a

District Coordinator appointed to Pakur. In Chatra district, meanwhile, Naxalite rebels created a hostile environment for outsiders, but the State Program Officer traveled there to conduct trainings, and later to launch a full set of activities. IRH received a letter of appreciation from the Deputy Commissioner for having come to Chatra in spite of the difficult environment. IRH also was invited to be part of Jharkhand's State Review Mission, further consolidating its role of credible development and resource partner to the state.

Due to its tenacity in pursuing scale-up objectives, willingness to work hard in trying conditions, commitment to establishing and maintaining a solid relationship with the MOHFW, transparency in sharing project data, and dedication to evidence-based practices, quality, and human rights, IRH became known within Jharkhand as a highly professional organization worthy of the government's trust. IRH positioned itself as a FP technical organization that aimed to strengthen the entire health system, rather than one that focused narrowly on SDM, and concerned itself with helping the MOHFW achieve its own stated goals. All these factors contributed to IRH's reputation as a credible, trustworthy, and hard-working organization. This reputation served scale-up well: it facilitated the strong partnership between IRH and the MOHFW, and thus opened doors to scale-up opportunities that would not have been accessible to other technical assistance agencies.

#### **1.4. The need to go beyond systems integration:**

IRH focused on integrating SDM into *systems*, which included CTU and CHW training curricula, policies, norms, budgets, procurement, inventory, information management, and IEC. Systems integration was at the foundation of all efforts and was essential to increase the likelihood that SDM scale-up would be sustainable over time. However, systems integration is clearly not enough to ensure the success of scale-up. Systems strengthening is required, in addition to a great deal of advocacy to ensure that actors within the health system carry out new policy directives.

If existing systems are weak, or if key systematic components are absent, there is in effect no system into which to integrate. For example, the Jharkhand MOHFW system lacked a cadre of trainers; did not issue government-sponsored IEC campaigns on birth spacing; and had relatively weak monitoring and supervisory systems. While the resource team worked to strengthen these systems--for example, by developing the training skills of providers within the MOH hierarchy--there is only so much influence it could exert over the user organization. For example, while the resource team could recommend that the government strengthen its supervisory system and work with supervisors on effective strategies for supportive supervision, it could not make the government hire additional staff. Certain conditions, in fact, may be beyond the user organization's control, such as limited budgets, an inability to find qualified workers to fill key positions or, in the Jharkhand MOHFW's case, the computerized system for tracking service statistics that was provided by the GOI and could not be changed to include SDM.

Another reason that systems integration alone is not enough is that integration into systems such as policies and norms does not always change behavior. Health systems consist of individuals, who must be convinced of the value of the innovation before they will integrate it into their work. The head of a district, for example, might receive a letter from the Health Secretary stating that SDM was now part of the state FP program and advising him or her to add it to district-level services. This person will need much more than a letter to internalize the value and urgency of the work and change behavior accordingly. Thereafter, these individuals must be reminded to integrate the innovation repeatedly over time so that it becomes ingrained.

### 1.5. Quality control when transitioning from introduction to scale-up:

When scaling up an innovation, maintaining quality services is a central concern. It is not possible to apply the same level of resources or oversight to a broad geographical area with a population of millions. It is therefore crucial that quality monitoring be an integral part of scale up. In the case of SDM, components of the innovation tested in the introductory phase had to be modified to make them more appropriate for scaling up, including training curricula, CycleBeads insert, and counseling guides. Quality monitoring was needed to make sure the modified innovation was as effective as the original.

IRH found that it was not always possible to maintain the same level of service quality upon scale up, especially geographic expansion. It had to consider whether the level of quality, although lower than in the concentrated introductory phase, was still good enough; if the quality was improving as scale up progressed and the innovation became more ingrained; if the resource organizations were doing everything possible to improve quality as scale up progressed, such as using M&E data to make program improvements; and whether the addition of the innovation, and the process by which it was added, represented a benefit to the overall FP program in Jharkhand state.

### 1.6. Sustainability:

Although significant progress has been made across the various components of the scaling up of the SDM at the state level, several actions must occur in order to continue to ensure the continued success of the scaling up of the SDM. These actions span multiple scale-up components including advocacy, capacity building, logistics and procurement, IEC, and HMIS/Monitoring & Evaluation. Key donors and partners such as USAID, HLL, and the Government of Jharkhand are necessary to further all scale-up components.

As the FAM project closes, it is important to continue to advocate both for support for SDM expansion from USAID and other donors as well as for SDM inclusion in national level policies and programs. Essential capacity building strategies include ensuring SDM is part of FP activities in new procurements, including SDM in state FP training programs & curricula, such as *Sahiyya* training, expanding SDM integration to remaining 12 Jharkhand districts, reinforcing SDM/LAM provider competency, and integrating SDM in other nursing schools following the successful example of Jamia Hamdard University. Logistics and procurement efforts should include the purchase of CycleBeads from HLL and advocacy for the purchase of CycleBeads. IEC approaches should ensure that SDM and LAM are included in IEC materials and campaigns. As scale-up continues in India, it is important to continue HMIS and monitoring & evaluation efforts. It will be necessary to monitor that SDM and LAM information is completely and correctly recorded in HMIS, ensure that HMIS have space included for SDM state-wide, and include SDM in the next state-wide survey.

Significant progress has been made across the various components of scaling up SDM at the state level. To assure that these achievements are sustained and/or advanced upon the end of the FAM project, however, IRH identified key actors and strategies that will play a critical role moving SDM forward in terms of advocacy, capacity building, logistics and procurement, IEC, and HMIS and M&E. See Table X for a table of action items and responsible parties committed to ensuring sustainability of SDM scale-up.

Table 11: Sustainability Action Plan

Scale-Up Component	Action for Sustainability	Responsible Party
Advocacy	<ul style="list-style-type: none"> <li>Advocate for SDM inclusion in national-level policies and programs</li> <li>Advocate for support for SDM expansion from USAID and other donors</li> </ul>	<p>USAID , HLL and GoJ</p> <p>GoJ</p>
Capacity Building	<ul style="list-style-type: none"> <li>Ensure SDM is part of FP activities in new procurements</li> <li>Include SDM in state FP training programs &amp; curricula, such as <i>Sahiyya</i> training</li> <li>Expand SDM integration to remaining 12 Jharkhand districts</li> <li>Reinforce SDM/LAM provider competency</li> <li>Integrate SDM in other nursing schools following the example of Jamia Hamdard University.</li> </ul>	<p>USAID</p> <p>GoJ, USAID</p> <p>GoJ, USAID</p> <p>GoJ</p> <p>GoJ, USAID</p>
Logistics and Procurement	<ul style="list-style-type: none"> <li>Purchase CycleBeads from HLL</li> <li>Advocacy for purchase of CycleBeads</li> </ul>	<p>GoJ</p> <p>USAID and HLL</p>
IEC	<ul style="list-style-type: none"> <li>Ensure SDM and LAM included in IEC materials and campaigns</li> </ul>	USAID and GoJ
HMIS/Monitoring and Evaluation	<ul style="list-style-type: none"> <li>Monitor that SDM and LAM information is completely and correctly recorded in HMIS</li> <li>Ensure HMIS have space included for SDM state-wide</li> <li>Include SDM in next state-wide survey</li> </ul>	<p>GoJ</p> <p>GoJ</p> <p>GoJ, USAID</p>