

# Standard Days Method® Scale Up in Rwanda: Interviews with Key Actors

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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 September 2007. 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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This report was written by Catherine Toth for IRH.

**The FAM Project**

Institute for Reproductive Health  
Georgetown University  
4301 Connecticut Avenue, N.W., Suite 310  
Washington, D.C. 20008 USA  
Email: [irhinfo@georgetown.edu](mailto:irhinfo@georgetown.edu)  
Website: [www.irh.org](http://www.irh.org)

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## Acronyms

<b>CSO</b>	Civil Society Organization
<b>CHW</b>	Community Health Worker
<b>DHS</b>	Demographic and Health Survey
<b>FBO</b>	Faith-Based Organization
<b>FP</b>	Family Planning
<b>FP TWG</b>	Family Planning Technical Working Group
<b>GBV</b>	Gender-Based Violence
<b>GoR</b>	Government of Rwanda
<b>IRH</b>	Institute for Reproductive Health
<b>HMIS</b>	Health Management Information System (see also SIS)
<b>JSI</b>	John Snow, Incorporated
<b>LMIS</b>	Logistics Management Information System
<b>MCH</b>	Maternal Child Health
<b>MCHIP</b>	Maternal Child Health Integrated Program (USAID)
<b>MOH</b>	Ministry of Health
<b>NFP</b>	Natural Family Planning
<b>NGO</b>	Non-Governmental Organization
<b>PSI</b>	Population Services International
<b>SDM</b>	Standard Days Method
<b>SIS</b>	<i>Système des Informations Sanitaires</i> (see also HMIS)

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## Executive Summary

### Background

From 2008 through 2012, the Institute of Reproductive Health (IRH) is implementing the Fertility Awareness-Based Methods (FAM) Project in several countries, including Rwanda. The FAM Project's dual purpose is to make the Standard Days Method® (SDM) widely available in Rwanda, and to integrate or institutionalize the method into the health structure. To accomplish these aims, IRH used the ExpandNet Model,<sup>1</sup> which guides strategic planning for scale up of reproductive health innovations—in this case, SDM—by taking into consideration the actions and decisions needed to secure institutionalization and geographic expansion of the method; the key actors who need to be involved; and the surrounding political, economic and social environment.

IRH's FAM Project (and the AWARENESS Project that preceded it) have coincided with a dynamic period in Rwanda. The government has prioritized population issues—notably, slowing rapid population growth to increase economic and social stability—and backs a strong family planning (FP) policy and program throughout the country.

In March and April 2012, as one component of the FAM Project's endline evaluation, 11 in-depth interviews were held with key partners and other important stakeholders who are active in FP in Rwanda and who have participated in the FAM Project. They included leaders, decision-makers and managers from the Ministry of Health (MOH), NGOs managing large-scale health projects, faith-based organizations (FBO) and donor agencies. The purpose of these interviews was to understand stakeholders' knowledge of the degree of SDM scale up in Rwanda, their attitudes towards scale up and towards the method itself, their insights into SDM's fit within the nation's socio-political environment, and their suggestions for ensuring SDM's sustainability within Rwanda's FP policy and programs.

### Results

The interview results are summarized here according to the major themes of the interview questionnaire.

*Understanding Scale Up:* Respondents were relatively well-versed in the topic of scale up in general. About half spontaneously mentioned one or more elements of vertical scale up

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<sup>1</sup> For more information on the model, see ExpandNet's "Nine Steps for developing a scaling up strategy" at <http://www.expandnet.net/guide.htm>

(institutionalization of a method) *and* horizontal scale up (expansion of a method). Nearly the same number referred only to horizontal elements when asked to define scale up. However, because IRH in Rwanda used the ExpandNet model as an internal document—it did not train partners in the model as IRH did in some other countries—this fairly weak result should not be too surprising. Upon being shown a diagram of the model and its main elements, stakeholders acknowledged the importance of institutionalizing SDM into government policies and procedures and readily mentioned how elements of institutionalization came about in Rwanda. Respondents' answers to the question, 'what are indicators that scale up has been achieved?' were fairly comprehensive. Still, about a third mentioned indicators of horizontal scale up only.

### **Scale Up Process and Principles**

Interviewees of all affiliations were very pleased with the FAM Project and with SDM. Several noted that IRH's approaches and strategies were appropriate and successful, and that the project and SDM both benefited from and contributed to the supportive environment for FP in Rwanda. The first of many comments was made here that SDM, as a method that is at once modern, effective and natural, was a true boon to FP in Rwanda (one interviewee called it a godsend) because churches accept it and indeed are largely willing to promote it. Religious institutions manage about 40 percent of health facilities in the country, and many of these facilities previously declined to participate in the national FP program.

Almost all interviewees understood that SDM scale up required an array of actors, including the church, the public sector and NGOs, and that IRH played a strong coordinating role in ensuring that scale up was participatory. When discussing informed choice and male involvement as values inherent to SDM, a Ministry of Health (MOH) respondent clarified that these values are also implicit in Rwanda's FP policy and program: 'FAM [Project] and SDM reflect these values, but they did not introduce them into the country.' A large majority of interviewees pointed out SDM's strong contribution to involving men in FP decisions and use; several went further and indicated that the method contributes to improved marital communication and harmony. Just over half of the stakeholders commented on the value of the research and evidence that has accompanied SDM scale up. In one important example, evidence that community health workers (CHW) are competent to counsel/distribute certain methods led to the CBD of FP methods, including SDM, which was piloted and is now being expanded in Rwanda.

When asked to describe external factors that influenced SDM scale up, most respondents mentioned the social and political environment in Rwanda and discussed its influence on *FP as a whole*. They noted how strong government leadership negotiated the post-genocide dilemma, introducing and promoting an FP program during a time when a surging

population growth—spurred in large part by a desire to rebuild families—threatened the ravaged economy and fragile peace.

A query about the impact of frequent turnover of MOH personnel on the scale up process evoked mixed responses. Several interviewees were clear that transitions in the government had no effect on SDM scale up because SDM was embedded in national policy; people might change, they said, but the policy does not. Another respondent, however, argued that regularly orienting new staff members wasted time and resources.

### Degree of Scale Up

Interviewees agreed that SDM scale up had been almost entirely achieved both institutionalization and geographic expansion of the method. Respondents stated that SDM was included or integrated in MOH policies, norms and guidelines; method mix; procurement system; logistics system; awareness-raising materials; plans and budgets; and provider pre- and in-service training. All agreed that SDM appears as a distinct method in the Demographic and Health Surveys (DHS). The one area where disagreement arose was the degree to which church health facilities accurately report on SDM in both the health management information system (HMIS) and the logistics management information system (LMIS). While three respondents indicated no problems, an equal number expressed concerns that anomalies would lead to inaccurate data on SDM's actual use or to ruptures in CycleBeads® stocks.

Of the stakeholders who discussed provider attitudes, all agreed that the majority of health workers now respect SDM and give it the same weight as other methods when counseling clients. Only one respondent could point to *evidence* of geographic differences, not in SDM scale up but in FP performance overall: Western Province lags behind the rest of the country in FP indicators, although the reasons for this are not clear.

### Specific Questions Regarding SDM

Respondents readily listed the advantages of SDM (male involvement, increased range of FP choice, has no hormones/side effects, is easy to use, and so forth) but the large majority was unable to cite a single disadvantage. In fact, the two disadvantages mentioned were peripheral to the method itself. ('As with condoms, the quantity you distribute is the quantity you think gets used, but you can't be certain.' 'The government is now prioritizing long-acting and permanent methods; SDM may get left behind.')

Stakeholders from all affiliations—MOH, NGOs and FBOs—acknowledged that SDM played a pivotal role in bridging differences between church- and state-managed elements of the health system. MOH and NGO respondents agreed that SDM gave the churches a solid

reason to participate in FP service delivery and thus in FP policy. The method, in effect, jump-started the active participation of church-run facilities in the national FP program. FBOs, for their part, indicated that the arrival of SDM prompted the Catholic Church in Rwanda to write policy and instructions for Catholic-run health facilities to more actively promote natural family planning (NFP) methods including SDM. One FBO respondent expressed relief that this SDM promotion has ‘had a positive impact on the state’s and other actors’ knowledge of the church’s role in FP...Church health centers are no longer considered zeroes by District Health Supervisors, as they were before.’

Several respondents pointed out the effective and professional role that IRH staff played in bringing church stakeholders into the circle of key partners in SDM scale up: ‘IRH sought and found solutions, pursued collaboration and negotiation...[they] really knew how to manage the various elements, opportunities [and] challenges.’

### Next Steps / Recommendations

In spite of the strong consensus that horizontal and vertical scale up is almost complete, three interviewees recommended that IRH extend the FAM Project for several years or otherwise ensure a strong transition period to solidify gains and capacities, especially among district trainers.

A greater number of respondents stated that it was up to both MOH and church leaders to develop and implement post-scale up strategies to maintain achievements, notably: ongoing training, supportive supervision of service providers and district trainers, and a consistent supply of training materials.

Other recommendations for the MOH were to:

- a. Increase community education efforts
- b. Deploy strategies to reach special groups (youth, women’s associations)
- c. Solidify CHW’s new (currently being piloted) FP work via follow-up and monitoring
- d. Add a Focal Point<sup>2</sup> role to CHW network; focal points would be qualified to distribute (rather than only counsel and refer) CycleBeads in communities

Finally, a handful of interviewees recommended research (to better understand and fill gaps in SDM information provided by church-run structures) and knowledge-sharing (with other countries on the integration and use of SDM).

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<sup>2</sup> Focal Points were district MOH staff who paid particular attention to SDM where scale up had less donor support; see also page 19.

## 1. Introduction

The Standard Days Method® (SDM) is a simple fertility-based method of family planning (FP) that helps women identify their fertile and non-fertile days to avoid unintended pregnancies. Developed by IRH in 2001, SDM is used with CycleBeads®, a simple tool in the form of color-coded string of beads that helps women and couples track their fertility. SDM is backed by several studies showing an efficacy rate of 95 percent with correct use, and 88 percent with typical use.<sup>3</sup> These rates put SDM on a par with other modern, user-dependent FP methods.

The Institute for Reproductive Health (IRH) first introduced SDM to Rwanda in 2002, in the midst of a very favorable political environment. The early 2000s saw a tremendous effort by the Government of Rwanda (GoR) to develop and support a strong FP program as the centerpiece of its response to a rapid population growth that threatened post-genocide recovery, prosperity and peace. USAID, an important supporter of health programs in Rwanda, invited IRH to develop and implement a project (“AWARENESS”) that not only introduced SDM to the country, but took the first essential steps in institutionalizing the method within the MOH. By 2008, at the close of AWARENESS and the onset of the follow-on Fertility-Based Awareness Methods (FAM) Project, SDM was integrated into the GoR’s FP policy, strategy, norms and protocols; service provider curricula; health management information system (HMIS); logistics management information system (LMIS) and supply system; and supervisory tools. SDM appeared as a distinct method among modern methods in Rwanda’s 2005 Demographic and Health Survey (DHS). CycleBeads and counseling were available via health facilities in about two-thirds of Rwanda’s health districts.

The FAM Project, guided by the ExpandNet model, has continued the process of scaling up SDM in Rwanda. IRH’s role has changed from implementation—as during AWARENESS—to *technical assistance* to the MOH and other key actors to achieve nationwide SDM expansion, to ensure the quality of service delivery, and to complete the institutionalization of the method at central and district levels. The MOH, meanwhile, shifted to become the leader of SDM scale up in Rwanda, and most recently has piloted the community-based distribution (CBD) of FP methods including SDM.<sup>4</sup>

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<sup>3</sup> Arévalo, M., V. Jennings, I. Sinai. “Efficacy of a new method of family planning: the Standard Days Method,” *Contraception* 65 (2002) 333-338.

<sup>4</sup> Community Health Workers (CHW), volunteers under the aegis of state-run health services, are providing counseling and supplies for three methods (condoms, pills, depo provera) and counseling and referral to health centers for SDM. Now in pilot phase, CBD is scheduled to go nationwide by 2013.

During the years that IRH worked in Rwanda, the GoR's 'redynamisation' of FP and its prioritization of population issues spurred significant change. In 2005, the total fertility rate was 6.1 children per woman;<sup>5</sup> just five years later it had dropped to 4.5. In the same period, the contraceptive prevalence rate among married women leaped from 10 percent<sup>6</sup> to more than 45 percent. Meanwhile, the MOH built very visible, increasingly responsive structures and teams to implement FP strategies throughout the country. Donors and NGOs recognized and acted within these structures. In short, SDM scale up in Rwanda occurred within a supportive political environment and cohesive health system. The socio-cultural environment, meanwhile, also showed evidence of accepting FP and birth spacing. This not only in the post-genocide context, but in a highly religious country where churches—especially the Catholic Church—manage up to 40 percent of all health facilities.<sup>7</sup>

For more information on IRH's achievements and challenges during the AWARENESS and FAM Projects, see the IRH Rwanda Scale Up Case Study Report (*forthcoming*).

In March and April 2012, as the first of several components of the FAM Project's endline evaluation, 11 in-depth interviews were held with selected stakeholders who are active in family planning (FP) in Rwanda and who participated in the FAM Project and SDM scale up. The *objectives* of the stakeholder interviews were to:

- a. Understand stakeholders' views and definitions of scale up, and in particular 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 and integrating it into their programs; determine stakeholders' current commitment and attitudes toward SDM.
- d. Determine what still must be accomplished to complete SDM scale up.

This report presents the results of those interviews, and is organized along the five broad themes that appeared in the questionnaire (see 2.2 below) with one exception. The topic of church/state collaboration, which is so pertinent in the Rwanda context, was addressed by stakeholders at numerous points during the interviews. To ensure that the information not

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<sup>5</sup> National Institute of Statistics of Rwanda (NISR) [Rwanda], Ministry of Health (MOH) [Rwanda], and ICF International. 2012. *Rwanda Demographic and Health Survey 2010*. Calverton, Maryland, USA: NISR, MOH, and ICF International. All numbers in this paragraph from pages xxi-xxii except that noted below.

<sup>6</sup> Institut National de la Statistique du Rwanda (INSR) and ORC Macro. 2006. *Rwanda Demographic and Health Survey 2005*. Calverton, Maryland, U.S.A.: INSR and ORC Macro. Page 54.

<sup>7</sup> Respondents typically indicated that 'about 40 percent' of health facilities are managed by religious institutions; a Catholic FBO specified that the Catholic church runs 29 percent of facilities (including health centers and hospitals) in Rwanda.

be minimized or lost, much of it is collected and presented in a specially created section, 'SDM Scale Up and Rwanda's Church and State Health Systems (3.4.2).

The information contained herein represents the interviewees' perceptions and opinions: the objective of this document is to convey those perceptions and opinions without corroboration or correction. The views of IRH staff may differ.

## **2. Methodology**

### **2.1 Interviewees**

Data collection consisted of 11 interviews with stakeholders who played diverse but important roles in SDM scale up in Rwanda (see Table 1, overleaf).

The 11 interviews were held with representatives of nine organizations. Of the nine organizations, two were within the GoR, one was a donor, four were international NGOs and two were FBOs. In two organizations, more than one interview was conducted. In two others, two people were present in a single interview, at the request of the organization in question.

It is important to note that many of the interviewees and/or their organizations were interacting with IRH as far back as the AWARENESS project with the introduction of SDM in Rwanda in 2002; they were not apt to view the ten-year span of IRH's work in the country as two separate funding periods or projects. As will be noted throughout, many responses refer to the entire 2002-2012 period, and not specifically to the 2008-2012 FAM Project lifetime. Most interviewees, likewise, implement or support Rwanda's FP program *as a whole*. Several interview question provoked reflections not on the SDM in particular, but on FP in Rwanda in general.

Interviewees signed informed consent forms that, among other things, stated that their names would not appear in association with their comments but that the title of their organization may. Knowing respondents' general affiliation can be useful for interpreting their observations. Therefore, comments are tagged MOH, Donor, NGO, and FBO.

**Table 1: Number, Affiliation and Job Title of Interviewees**

Organization and Division or Specialty		Title(s)	GoR	Donor	Civil Society	
					NGO	FBO
# of interviews						
MOH	FP Integration Unit within Maternal-Child Health Division	Director	1			
District MOH	First-level decentralization; oversee all health facilities and functions in one of Rwanda's 30 health district	Director, Nurse Supervisor	2			
IntraHealth	Implemented several health projects in Rwanda that, combined, were near-nationwide for about a decade	Director, Policy Advisor			2	
MCHIP	Bridges the gap between the IntraHealth projects and an upcoming, large-scale health program (USAID-funded)	M&E Leader			1	
JSI	Provides technical assistance to GoR for procurement, logistics of all essential medicines including contraceptives	Director, Technical Advisor			1	
PSI	Social marketing of several contraceptive methods including SDM/CycleBeads	FP Coordinator			1	
Action Familiale	Member of an African Federation of FBOs that implements Catholic church-supported health, development and social programs at community level	Director				1
Caritas	Catholic church's development organization, with three branches: health, social work, development	Medical Coordinator, M&E Specialist				1
UNFPA	Provides portion of funding for FP methods nationwide; directly supports several health districts in Western Province	Reproductive Health/Rights Officer		1		
<b>Totals</b>			<b>3</b>	<b>1</b>	<b>5</b>	<b>2</b>
<b>11</b>						

## 2.2 Interview Tool

The questionnaire was prepared by IRH staff in Washington, D.C., and administered in Rwanda by a consultant. The questionnaire contained five broad themes:

1. Understanding Scale Up
2. Scale Up Process and Principles
3. Degree of Scale Up
4. Specific Questions on SDM Scale Up
5. Next Steps/ Recommendations

Each theme contained several specific questions. The questionnaire also contained dozens of suggested probes.

The IRH Coordinator in Rwanda and the consultant carefully reviewed the questionnaire before conducting interviews. In consultation with IRH in Washington, the wording of several questions was simplified and/or modified to better reflect events in Rwanda. Care was taken to retain each question's original intent. (See Appendix I for the Interview Guide with original and modified questions.)

Because the questionnaire was designed for use in all five FAM Project countries, which have very different implementation histories, not all questions proved useful or pertinent in Rwanda. (Nor, of course, were all questions relevant for all interviewees.)

One interview was held in English, and ten in French. The duration of interviews ranged from 45 minutes to 1.5 hours. In one interview, the recording equipment malfunctioned, leading to the loss of about 15 minutes of discussion. The consultant filled in missing information from memory as much as possible. All subsequent interviews were recorded using two machines.

### **3. Results**

Results are presented according to the five themes of the questionnaire and the questions/probes within those themes. Subtitles indicate the nature of specific questions, but are typically abbreviated versions of the questions themselves.

#### **3.1 Understanding Scale Up**

Unlike in several other FAM Project countries, IRH in Rwanda did not specifically train its key partners in the ExpandNet Model. Neither, for that matter, did it formally appoint a resource team.<sup>8</sup> Rather, at the project's onset, relevant actors gathered to identify achievements made during the AWARENESS Project, to pinpoint the remaining gaps and priorities, and to develop a joint plan to complete SDM scale up in Rwanda during the FAM Project. IRH staff used the ExpandNet model to guide and assess its own and key actors' work during the FAM Project, but the model was not overtly used by or with these actors.

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<sup>8</sup> 'The resource team refers to the individuals and organizations that seek to promote and facilitate wider use of the innovation. A resource team may be formally charged with promoting the innovation or may act informally in this role.' *Nine steps for developing a scaling-up strategy*, World Health Organization 2010. Page 6.

### 3.1.1 What do you understand scale up to be?

It is not surprising, then, that stakeholders did *not* refer to the ExpandNet Model when responding to the interview’s first question. Instead, they relied on their own experience, including (given the context of the discussion) that specific to SDM.

**Table 2: Responses to the question “What do you understand scale up to be?”**

Contents of responses	Number who Mentioned
Mentions only horizontal element(s)	4
Mentions only vertical element(s)	1
Mentions vertical and horizontal elements	5
Mentions research and pilots	4

The very words ‘scale up’ or ‘*mise à échelle*’ indicate *size*, and four respondents’ answers were limited to horizontal or expansion elements. Two of these also made clear that expansion took place only after research proved that the service or method was successful (acceptable, feasible) in some way. For example:

‘It means to increase something in size or money, to extend.’ [FBO]

‘If you want to introduce a product or service, you test to see its impact on the population. After the trial you can expand it on a larger scale.’ [NGO]

An NGO respondent mentioned only elements of vertical scale up, but horizontal elements may be presumed to exist in ‘sustainable programs.’

‘Behind it [scale up], there is a scientific innovation that has been studied, verified, tested; it has proven its impact. Now, scale up is how this...will be used to develop policies, programs and strategies that a country can use during a given period of time. That is how I understand the passage to scale: from a proven and tested scientific innovation, that allows a government—politicians and planners—to develop policy and sustainable programs.’ [NGO]

Half of respondents mentioned one or more elements of horizontal and vertical scale up, and their responses (three cited here) range from very simple to comprehensive:

‘It means that the program is available at all service sites nationally, whether public or private, and all service providers can [are trained to] offer it.’ [NGO]

'It is the way of making a service available to everyone...in Rwanda, for the method we are speaking of, we have integrated it into the national distribution chain.' [NGO]

'Scale up is about...improving accessibility to a service. And [it] is about integrating numerous things. At the national level we work to put in place policies, to have a strategic plan and to make sure that health facilities and CHW are doing activities according to national standards and norms, according to the FP policy. [W]e have teams at district level to coordinate and supervise activities...we also look at how all levels can be trained and equipped, and can interact with the population to provide information and orient people how and where to get FP services.' [MOH]

After this initial question, respondents were shown a diagram of the ExpandNet Model and given a brief explanation of its components. The interviewer took care to describe the importance of both the vertical or institutionalization axis, and the horizontal or expansion axis, as sub-components of *organizational processes*. Only one respondent mentioned having seen the diagram before.

Upon reviewing the diagram, one stakeholder from the NGO sphere took the stance that early progress (during AWARENESS Project) along the horizontal axis pushed or forced progress along the vertical axis:

'Sitting with service providers, authorities like the *chargé des affaires sociales*, community representatives like religious leaders, and the private sector and CHWs...this helped us launch SDM in communities. Once they took ownership of the method, it made it so much easier than waiting until [SDM] was inscribed in policy. We went immediately into the horizontal aspect because we had providers, community, authorities who supported the method...The results were rapid because ownership was already in place...It was the community that pushed us to...certain directives. Sometimes it is very interesting to start on the horizontal and force the vertical. That is what happened here.' [NGO]

### 3.1.2 Indicators of successful scale up

After seeing the ExpandNet diagram and hearing specific mention of vertical and horizontal axes, five respondents cited at least one indicator of scale up on each axis. One of the simpler answers was, 'scale up is complete when everything is integrated in the health system, and beneficiaries are using the method well. People take ownership, and it becomes our normal way of doing things.' The interviewee whose response was the most comprehensive began with the vertical ('the innovation is present in...FP norms, FP policy,

*Selected indicators mentioned by respondents:*

- Rise in CPR
- Acceptability of method
- Number and type of new users
- Length of use
- Autonomy of users
- Client satisfaction
- Widespread knowledge
- Widespread availability
- Widespread access
- Method is present in SIS
- Method is present in service provider training
- Method is present in information systems
- Method is present in procurement and logistics systems
- Normalization ('a method like any other,' 'our normal way of doing things')

the list of essential medicines; it is in training guides and materials'), continued to the horizontal ('people are informed, they know how to obtain the method, the service providers are trained...the coverage across the country'), and concluded with evidence of impact ('the role of the method in the contraceptive prevalence rate (CPR), in reducing fertility, and in the number of children per woman or household'). [NGO] [8]

Four respondents mentioned only horizontal or expansion indicators, even after being exposed to an overview of the ExpandNet model.

Five interviewees mentioned sources of information from which to draw data on indicators, and in most cases these sources are, themselves, indicators of vertical scale up. For example, the NGO interviewee quoted above stated that data on SDM scale up could be found in the DHS, MOH

annual reports, supervision reports, the HMIS (known in Rwanda as the *Système d'Information Sanitaire* or SIS) and the *SIS-Communauté* (SISCOM). The very fact that SDM appears as a unique data category in these sources is itself an indication of the methods' institutionalization or vertical scale up.

### **3.2 Scale Up Process and Principles**

#### **3.2.1 How did SDM scale up happened in your program or organization?**

Each of the ten responses to the first part of this question—how did SDM scale up happen in your program/organization?—reflects a unique organizational experience. This report, therefore, will make only a limited effort to point out common and dissimilar experiences among respondents (see Table 3).

Of note, two respondents represent organizations whose participation in SDM scale up in Rwanda began only with the FAM Project in 2008. All other respondents represent organizations that have been involved since the onset of the AWARENESS Project in 2002. (That said, two of these respondents joined their organizations much later, in 2008 or 2009.) In summary, four respondents to this question recounted an SDM history of about four years' duration, while six offered a ten-year history.

### 3.2.1.1 What did and did not work well?

**Table 3: Common elements in response to the question, “How did SDM scale up happen in your organization?”**

Respondent mentioned...	Number who mentioned
Being involved in national level collaboration	7
curricula development and service provider training	6
service provider supervision	5
integration of method in other national systems	4
research, special studies	2
SDM's unique and useful role in FP method mix	4

Respondents were overwhelmingly positive about their involvement in the FAM Project (and AWARENESS previously), and in their assessment of SDM scale up as a whole in Rwanda. The most common response to this probe was, **‘everything I mentioned [in answer to 3.2.1] went well.’**

However, whether in direct response to the probe, or in their overall response to 3.2.1, several stakeholders singled out things that went especially well in the scale up, including IRH’s approach and methodology. One respondent reflected back to the earliest days when IRH introduced SDM, a new method in Rwanda’s dynamic FP environment. Rather than insist on an independent identity, this stakeholder said, IRH willingly attached itself to a large-scale USAID-funded health project that had already established working ties with the MOH. The respondent called this a ‘small, not brutal introduction’ and compared it to entering via a small door:

‘To be accepted at the level of existing programs, [IRH] entered by a small door. They came in by this small door and they did not immediately state, ‘here is our program...’ This little door opened all the doors – these doors were to the districts, the district supervisors, the service providers at health centers, and thanks to this they were became embedded at the level of ministers. Of course this was abetted because there were things they did, such as trainings, and each time there was a training, [IRH] had to be there... they did not do advocacy as such...no, they implemented, they were in the modules, in programs, they went into the field. They used the approach of integration, integration, integration, and after a while [came] the ownership that I mentioned.’ [NGO]

A donor representative corroborated that IRH’s earliest approaches served well, not only in the AWARENESS, but in the FAM Project as well.

'What worked well...even as far back as how IRH introduced the method.<sup>9</sup> It began with meetings and advocacy...[and] the method was accompanied by lots of tools, IEC and BCC. We did meetings at national and peripheral levels; we went down to decentralized levels to make sure it was introduced in the public and religious milieux. Also, advocacy and involving all stakeholders...politicians, even parliamentarians, and agencies whether USAID or bilaterals or UN. Everyone was brought to the same level of information at the beginning. I think this worked very well, and it's why we registered such good results, as you see today.' [Donor]

A different NGO stakeholder described IRH's somewhat changed role (from direct implementation in the AWARENESS Project to technical assistance in the FAM Project): 'There was always communication, collaboration, and an effort to find solutions to problems. I think that's the role that IRH played in scale up.' [NGO]

Two more stakeholders mentioned the supportive political and social environment for FP in Rwanda:

'The SDM project<sup>10</sup> helped us strengthen our indicators and results vis-à-vis USAID, and of course the problem of post-genocide Rwanda [where] FP was very difficult for the population to accept. This method helped us gain ground compared to methods that were not accepted by the general population, the Catholics, the culturalists. [Our NGO] was in its infancy in Rwanda, and this method helped strengthen what we could say to Catholics, to churches. It helped us easily attain our results.' [NGO]

'The first thing that worked well is that the government accepted and was really engaged in this innovation. [SDM] was judged effective and the government took ownership of this effectiveness to integrate it into its policies...the content of FP training...the didactic materials...' [NGO]

The same respondent continued with an observation on SDM scale up's contribution to service quality:

'When you are face to face with a service provider who has been trained on SDM and one who has not, you can see a real gap when it comes to anatomy and physiology. SDM training strengthens the knowledge, the ease of providers, especially on the physiology of reproductive systems.' [NGO]

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<sup>9</sup> In 2002 at the onset of the AWARENESS Project.

<sup>10</sup> Also referring to the AWARENESS project.

When asked specifically to reflect on what did *not* work well, respondents were able to identify only a handful of difficulties, all of which were linked in some way to reliable data, either on SDM use (as reflected in the HMIS or the DHS) or SDM procurement or supply (as reflected in the LMIS). (See 3.3.1 for more on this topic.)

An interviewee who specializes in monitoring and evaluation was concerned that SDM use is underreported, in spite of success in assigning the method its own unique category in data collection tools. 'Even those who use SDM and you ask them what they use, they are likely to answer *traditional method*. It's CycleBeads but gets classified as a traditional method.' This individual also worried that SDM users will, when queried, cite the method (such as condoms) that they use during the fertile period. 'When you see users of barrier methods—the male condom—is it truly likely that the couple...uses condoms from January through December? Behind the condom, there must be another method...How can we clarify the part that SDM plays in the use of other methods?' [NGO]

An FBO stakeholder mentioned initial difficulty in proving to the MOH that church-run health facilities could contribute to achieving national FP goals. 'The state's stance was that the church wasn't doing anything—that we just talked about natural methods and didn't have any results...We are proud of how we work, but we needed to sell our work, to get credible data to the MOH. At the time, the SIS had no category for natural methods. With advocacy with FAM [Project], we made that happen. We were able to show data for natural family planning (NFP).'

This respondent went on to mention ruptures in the supply of CycleBeads in district pharmacies. 'Often, because there is high demand, they don't manage to have enough of the CycleBeads they need at district pharmacies. That's a problem, and we always call on FAM [Project staff] to help us resupply.' [FBO]

An NGO respondent who supports the national logistics system expressed concern that not all church-managed health facilities participate in the national SIS and logistics management information system (LMIS). According to this interviewee, the national system requires that health districts report on distribution or use of a product (gathering data upward from CHW to health facilities to district hospitals) before they can order a resupply. He stated, 'It is that mechanism that allows us to see the different uses of the products.' But the Catholic facilities 'don't give information about what was given to clients and what is the quantity remaining. That is the information we are missing: everything that happens with these *éducatrices* (equivalent to the state CHW) and the Catholic health centers, because they don't report.' [NGO]

### 3.2.1.2 Was SDM scale up similar to/different from scale up of other health innovations?

Most respondents did not feel well-positioned to reflect on the scale up of health innovations outside the FP realm. Among those who did, two stated that the mechanics of scale up were similar regardless of the product or service in question. A logistics specialist noted that, within the procurement and distribution system, the scale up of SDM is no different from any other medical product. ‘For us, everything depends on the government’s decision. If [they] decide to make something available to the entire population, we make it happen. It is the same process.’ [NGO] Meanwhile, a donor representative noted, ‘facilitated by good governance and decentralization here in Rwanda, I think that other scale ups are very similar. I don’t see much difference.’ [Donor]

Several respondents stepped away from scale up processes *per se* to discuss the impact of popularity on the scale up or acceptance of various products. One compared SDM to Jadelle™, which was introduced in Rwanda in 2007: ‘Jadelle had an *ascension fulgurante* (meteoric rise) compared to CycleBeads...our numbers can tell us that one product goes fast and others rather slowly. Among the slow products is CycleBeads.’ [NGO]

Taking a longer and contrasting view, several interviewees from the NGO community recalled that that SDM’s introduction in Rwanda (in 2002) ‘created a shock...it was an innovation that was not entirely a natural method but was between natural and modern methods. It was truly a godsend. We took ownership, the population took ownership...the community accepted it immediately. That was the reason the method covered the whole country in so short of time.’ [NGO] Another observed that ‘there was a need among certain women due to their religious beliefs, who couldn’t use modern methods...Now [with SDM] there was something concrete that was natural, that could help this group of women. For other scale ups, maybe for some curative service for example, you’d have to make a great effort to raise awareness among the population. But SDM—when people heard about it, they wanted it.’ [NGO] See 3.4.2 for more on SDM’s role as bridging element between church and state systems.

### 3.2.1.3 The principles and values behind SDM and its scale up

The stakeholder questionnaire was modified slightly in Rwanda to ask specific questions about several principles or values that guided SDM scale up. Each of these was presented in a sentence or two, and respondents were asked to describe their experiences with the principle or value.

## Principle 1: Scale up is participatory and multi-organizational

Almost all respondents made clear, when describing their organization's role in SDM scale up, that they understood and valued the participatory nature of the process. A respondent from the MOH rapidly listed the types of participating organizations—public sector, private sector, social marketing and FBOs—and acknowledged each one's pertinence to the overall success of (a) SDM scale up and (b) FP policy as a whole in Rwanda.

An NGO respondent looked back in time and said, 'If I recall, there were only two people on [IRH] staff. Two people cannot bring anything to scale. They knew how to collaborate, beginning with the MOH, then other development partners and partners in the districts. It was not IRH alone: they oriented the work, but all partners working in FP played a role. And service providers and the population were enthusiastic and invested themselves in the scale up.' [NGO]

The respondents who were less likely to acknowledge the participatory aspects of scale up were—not surprisingly—those whose work is partly or largely outside the MOH structures where most collaboration occurred. These were the social marketing organization (the interviewee spoke of collaboration with IRH only) and the two FBOs. The latter likewise mentioned collaboration with IRH, but spoke mainly of working within church structures to embed SDM in the services they offer. When speaking of their interactions with state health structures, in fact, these respondents spoke less of collaboration and more of their efforts to maintain church identity in the face especially of the GoR's strong FP policy and mix of modern methods. For example:

'[W]e said...abstinence during the fertile phase is a fundamental criterion for us. If couples practice abstinence, we are ready to join the experiment. As the material already in use mentioned protected sex, we put the condition that there be new materials that respect the identity of our organization.' [FBO]

## Principle 2: SDM values include informed choice and male involvement.

An MOH stakeholder clarified that both these values are implicit in Rwanda's FP program: 'FAM [Project] and SDM reflect and support these values, but they did not introduce them into the country.' [MOH] The same respondent described one way that the MOH has operationalized its commitment to informed choice when it comes to FP as a whole (though not SDM in particular):

'I think Rwanda is a special country in that we have a high percentage of health facilities managed by churches, especially the Roman Catholic church which doesn't accept modern contraception. Because of this, we have an agreement between the government and churches to make sure that information is comprehensive and covers all methods. So...they can provide information and if clients want a modern method, they are referred to the nearest state health facility or secondary health post. In Rwanda, we make sure to put secondary health posts [that offer all methods] near the church facilities to help the population have access to services not provided by FBOs.' [MOH]

All stakeholders agreed on the importance of male involvement, and all but two felt strongly that SDM played an important role in bringing the involvement about. Moreover, several described how SDM serves not only as an FP method but as a tool to improve couples' communication. A handful of typical observations:

'SDM really strengthened men's involvement in the FP program. SDM was for me a pipeline, a boost, for increasing men's engagement in FP in general and SDM in particular.' [NGO]

'A good introduction to [SDM] improves marital communication. Even if the couple doesn't choose SDM but accepts another method...at least you've had the chance to stimulate conversation and clarify that whatever method they take, it is *theirs*. Before, it was really the woman's choice. This is truly an advantage that other methods do not have.' [MOH]

'It's really something in my opinion that contributed to couples' communication, especially on sexuality. It makes women more likely to [be able to] negotiate sex, to say yes or no. I like to chat with clients, and they say that now we discuss sex, though it was formerly considered taboo in Rwanda's culture. If a couple communicates and makes [an FP] choice together, that increases their chance of success. In my opinion, and I hope research can confirm this, SDM has really contributed to this.' [Donor]

Of the two respondents who did not extol SDM's role in promoting male involvement, one represented an FBO whose position was that, 'for [us], any method is above all a couples' method. It is never for a woman or for a man. For us it is a determining factor: the participation of a man no matter what method'<sup>11</sup> [FBO] [4]. The second specialized in

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<sup>11</sup> By contrast, MOH policy states that any woman or man is free to seek an FP method without the consent of his or her partner. The exception is permanent methods. A married individual seeking a permanent method needs the consent of his/her spouse.

social marketing, and noted, 'We didn't do anything special around [male involvement], with SDM or any other method. Just now we are beginning a big campaign around the support of the husband to encourage the wife in the use of FP.' [NGO]

### Principle 3: SDM scale up process should help strengthen the health system.

Two stakeholders (one NGO, one FBO) responded directly to this broad question, while most others described SDM's support to specific aspects of the health system (provider training, HMIS, etcetera) as part of their response to other questions. The NGO respondent pointed out that '...the project helped a lot in the Family Planning Technical Working Group (FP TWG),<sup>12</sup> with its support to communication and training. It was very important.' [NGO]

The FBO stakeholder, upon being asked this question, referred to IRH's Most Significant Change<sup>13</sup> research and in fact quoted from the FBO's own submission to that inquiry:

'Before the arrival of SDM, the state did not consider the church's contributions to FP in spite of the work done in our centers. The NFP data from our centers were not integrated in the SIS. In the SIS reporting format, there were only slots for artificial methods. But with advocacy done by those who initiated SDM, natural methods were added to the format, and this has let us show the work we do.' [FBO]

Thus while this change was important for the church, it also strengthened the SIS by more clearly differentiating one method from another. See 3.3.1 for further discussion of stakeholders' perceptions of remaining gaps in church and state information systems, and 3.4.2 for more discussion on how the FAM Project contributed to bridging other gaps between state- and church-run health institutions.

### Principle 4: SDM scale up should be based on evidence.

Of the six stakeholders who specifically discussed evidence surrounding SDM, three spoke of the MOH's 2008 study into community-based distribution (CBD) of selected FP methods.<sup>14</sup> One said:

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<sup>12</sup> The FP TWG is an active, important committee within the MOH's FP Integration Unit that brings together public sector, donor and NGO personnel to plan and coordinate the work of all FP stakeholders in Rwanda.

<sup>13</sup> See *Rapport de la Sélection Finale des Récits du Changement le Plus Significatif au Rwanda*, Institut de la Santé Reproductive/USAID/FAM, April 2011.

<sup>14</sup> The MOH and FP partners conducted an assessment to explore the feasibility of community-based distribution of several methods. Positive results led to the design of a pilot project that, in its turn, was assessed with satisfactory results in late 2011. CBD is now being expanded to several other areas, and full scale up of the program is anticipated in 2012.

'Right now we're scaling up CBD, integrating SDM and even injectables in methods given by CHW.<sup>15</sup> We began in three districts. When we evaluated after six months, we found tangible results. We added six [more] districts and by 2013 we'll be in all districts. There was at first resistance, especially for injections, and especially by doctors. We did a feasibility study before. It is a bit different for SDM, where we didn't do a feasibility study, because it was clear there was evidence and that it should be service providers who administer the method. So we didn't do that step here.' [Donor]

Two MOH stakeholders also mentioned the inclusion of SDM counseling in CHWs' work; one of these linked it to the concept of *task shifting*. In Rwanda's badly understaffed health system, he explained, the MOH is choosing to have nurses take on certain tasks that were once done by doctors, and CHWs take on certain tasks that were once done only in facilities. 'Evidence, for example that CHWs can successfully counsel clients on SDM use, is obviously very helpful in the process of task-shifting.' [MOH]

An FBO respondent clarified that sound evidence on SDM (or any other method) should be woven into client counseling to ensure informed choice, on one side, and service provision quality, on the other. 'What I see in the field is that some organizations or services present SDM as the simplest method, as accessible to everyone. If it is presented like that, it could...create confusion. But in [church-managed facilities], the results<sup>16</sup> are presented clearly and people understand: this helps a great deal.' [FBO]

### 3.2.2 External factors and SDM scale up

When asked to describe any external factors that influenced SDM scale up, several stakeholders spoke at length about the unique **socio-political environment** surrounding *FP as a whole* in Rwanda. On the political front, one MOH respondent described the post-genocide population dilemma: 'After the war, everything was destroyed. We had to start over...people weren't working and the economy was at zero. And people wanted to have children, saying that they had lost so much.'

'But,' he continued, 'by 1997, 1998, we saw that the population had already grown by a third [from pre-war levels] and that the national economy, national production, could never keep pace with *une surpopulation galopante*' (galloping overpopulation). The

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<sup>15</sup> To clarify, CHWs are providing counseling and education on SDM, but referring interested clients to health facilities to obtain CycleBeads and further counseling. CHWs are, however, directly providing pills, condoms and depo provera to clients.

<sup>16</sup> Referring to SDM eligibility, SDM effectiveness.

government had to act, he noted, to slow population growth, at a time when individual families seemed least likely to accept the national need to do so. [MOH]

The GoR has since strived to balance this tension between national priorities and individuals'/families' reproductive desires, guided by its ambitious FP and population policies—and clearly, it has been quite successful.<sup>17</sup> To explain the rapid scale up of FP as a whole, an NGO stakeholder observed the importance of:

'...the political engagement of our leaders, who welcome the largest possible range of FP methods available, to help the population adhere to the FP program. This spirit of openness to all methods that are scientifically proven, of accepting them in the country, has been a very important factor, in my opinion.' [NGO]

Another NGO respondent noted that, 'in Rwanda we have very strong leadership. When leaders understand the importance of something, it [becomes] country wide...When I speak to people from other countries about how Rwanda has succeeded in its FP policy, their response is, 'but our country is not like yours.' I have to acknowledge that Rwanda is, in fact, unique.' [NGO]

In a nation where up to 40 percent of health facilities are run by the Roman Catholic or other churches, the government is not the only authority that counts. One FBO respondent clarified that the National Assembly of Catholic Bishops has given instructions that church-managed health facilities should *actively promote* NFP including SDM:

'We...advocated with the Bishops' conference so that they would give clear instructions, create a clear policy for the dioceses, to say that now our NFP program will be done like such and so. They themselves required that there be a trained service provider, and a sign clearly stating 'NFP services,' in each center.' [FBO]

### **3.2.2.1 Government transitions.**

The government as a whole has been stable during the FAM and AWARENESS Projects, yet there were several personnel changes at high levels within the MOH. Of the three stakeholders who specifically answered this probe, two stated that staff turnover had no effect on scale up:

'Even if the minister or director changes, the policy does not. The policy is clear, so there have been no particular obstacles.' [Donor]

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<sup>17</sup> In the words of a different MOH respondent, 'We know that in 2000, the CPR for modern methods was at 4 percent. In 2010, it was at 45 percent. You see, from 4 to 45 percent is, I think, a very, very good achievement in just ten years.'

‘The minister or whoever can change, but the policy remains the same. And you know, here in Rwanda the environment is favorable, the policy in terms of FP is 100 percent, and the commitment is there, politically and socially, centrally and in villages.’ [NGO]

The third respondent took an entirely different viewpoint:

I think it plays a huge role. There was a reduction in the number of personnel at the central level. And those in charge of FP...since 2005 I think we’re on the fourth. Even for MCH, I think there have been three [leaders] since 2005. [T]hey leave and another comes in and it takes time to learn, to understand, and then he leaves. I think that...the FP program as a whole has suffered because of instability. [NGO]

### 3.2.2.2 SDM champions.

Five respondents identified champions or promoters of SDM, and three described champions of FP overall. However, only twice was the *same* champion or category of champion mentioned.

#### SDM Champions

- The director of the FAM Project: ‘I have been impressed how she has promoted it at every opportunity—in meetings, conferences, in the field.’ [NGO]
- Certain service providers (2 responses): ‘They just get it, and then they help others understand.’ [MOH] ‘[T]hey don’t stay at the center but go out into communities to raise awareness among couples.’ [MOH]
- Focal Points<sup>18</sup>, of which the respondent was one: This stakeholder was proud of having taken the initiative to census, via CHWs, FP use in one district. He found several dozen SDM users who had not been registered as such, perhaps because they obtained their CycleBeads during an MOH-sponsored campaign rather than at a health facility. [MOH]
- The Minister of Health [NGO]
- Certain users (2 responses): ‘They help spread the message.’ [?] ‘Couples who have themselves used the method, who go out and talk to others...We are Catholic but we have Muslims, Protestants who go into their communities and raise awareness among others...and they send people to get more information.

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<sup>18</sup> IRH and MOH developed the role of focal point in districts where SDM scale up had less donor support for training and supervision. The focal points were district MOH staff who paid particular attention to SDM, used supportive supervision and special supervision tools to reduce service provider bias against the method, collected and centralized FP user statistics that were not being gathered. See the IRH Rwanda Scale-UP Case Study Report (forthcoming) for further information.

They are better placed to explain because they speak of their own experiences.’  
[FBO]

#### FP Champions

- Elected officials: ‘[W]e have a network of parliamentarians working on issues of population but especially FP. We have a strong team there, so issues of advocacy, operationalization, awareness raising...they are working on it in a very big way. Also in Rwanda there is a presidential initiative...All authorities, political and administrative at each level, have to talk about RH and FP to help the government implement [its] different strategies on population.’ [MOH]
- Contest winners: ‘In my project...I promote champions. We have journalist champions, and authority champions. We have given prizes to FP users, or FP use champions. We don’t specify methods—we just award for FP stories in general.’ [NGO]
- Church personnel: ‘Sisters and priests...of course, they are not users but they accompany, they facilitate, they give space, they encourage. There are priests who are really behind the NFP program.’ [FBO]

#### 3.2.2.3 Human and reproductive rights, gender equity

Two respondents were asked about Rwanda’s human and reproductive rights environment as an external factor that affected SDM scale up; both spontaneously mentioned the principle of informed choice in their observations.

‘For FP, we consider [human rights] at all levels. [F]or planning, implementation and information at community level, we consider this component. We position FP as not only for women, but for both men and women, and we promote that it be discussed at family level, a woman and her partner to take decision together.<sup>19</sup> Also to have all information, to make a clear choice...I think human rights is now a topic everywhere. When we are making documents like policy or guidelines, we take human rights and *[with prompt]* gender equity into consideration... So we are aware of this issue, and the government of Rwanda has integrated it in all programs.’ [MOH]

‘Yes, of course. We consider human rights, and as FP and deciding the number and spacing of children...is a free and informed choice, we must include human rights in training. It’s linked to policy, to training modules and checklists, it’s fully linked.

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<sup>19</sup> This respondent later clarified that permanent methods do require the consent of both spouses as noted above. Men and women can choose any other method independently.

And we don't even require the presence of the partner to offer a method. Unless, of course, the method requires communication, then the partner is needed.' [Donor]

Upon being prompted to reflect on SDM use in a culture that traditionally says a husband has access rights to a wife's body at all times, the same individual continued:

'Even if one speaks of conjugal violence, we now have a penal code for that. Gender-based violence (GBV) includes conjugal violence. All communities are informed...[and] they have instructions [for dealing with] GBV and conjugal violence. Before, it was truly rape. The man would come home drunk and say, 'look, I paid a dowry for you so I want sex now.' There is a change in mentality. There are clear instructions, that GBV includes conjugal violence, physical and sexual violence.' [Donor]

Finally, an NGO stakeholder mused that 'SDM might be a useful tool that, in addition to being a FP method, could reduce violence in the home, increase harmony, and even reduce waste [of money]. It's something to measure, to see from a scientific manner, what is happening.' The respondent summarized changed views of SDM: early on, he said, women who were offered the method 'used to say, 'No, my husband comes home late after drinking' [and demands sex.] Now they say, '[our neighbors] think I've bewitched him because he doesn't go to bars. He comes home, and we deal with our problems together.' [NGO]

### **3.3 Degree of SDM Scale Up<sup>20</sup>**

#### **3.3.1 To what degree has SDM been fully integrated into your program / country?**

All respondents recognized the very high degree to which SDM had been scaled up in Rwanda, both vertically and horizontally. In a number of cases, the discussions preceding this set of questions had so strongly established the advanced nature of scale up that queries about specific systems and levels were asked more as a 'yes/no' checklist than as a series of probes.

The table overleaf summarizes responses to question 3.3.1. For all but one element questioned, it shows that stakeholders claimed confidence that SDM was fully integrated in

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<sup>20</sup> The questions about degree of SDM scale up were preceded by a display of the FAM Project benchmarks table (see Appendix II) for Rwanda as a whole. The table proved more confusing than enlightening to interviewees, who clearly viewed SDM scale up, both institutionalization and expansion, as quite complete. IRH's internal benchmarks, and the presence of LAM in the table, provoked several questions. In short, the responses discussed in this section were sparked less by the benchmarks table and more by each stakeholder's own experience and knowledge of SDM scale up in Rwanda.

national structures. The table includes several useful comments supporting those claims of integration. However, three respondents pointed out exceptions to the integration of SDM, in the category of information systems. More specifically, all three expressed concerns that gaps still exist in church-run facilities' reporting, both in the HMIS and the LMIS.

**Table 4: Observations on Institutionalization of SDM**

Is SDM included in...	Respondents Consider Integration Complete	Context and Supporting Comments
...policies, norms, guidelines?	Yes	'In 2005, we elaborated the FP policy. The policy said, 'all existing types of contraception,' and this included SDM...If it is in the policy, it leads to the strategic plan, which...includes logistics, budgets, who will finance what...In sum, integration after policy is automatic.' [NGO]
...method mix?	Yes	'At (social marketing NGO), our range of methods was too limited. So SDM expanded the mix we could offer...and because we are first of all a communications organization, it allowed us to do a great deal of communication and gain the confidence of our target group.' [NGO]
...procurement system?	Yes	(Donors and the MOH maintain a logistics committee to plan, project, procure and pay for essential medicines including FP methods.) 'The government has just begun to allow a certain sum of Rwandan francs to contribute [to the purchase of contraceptives]. So without worrying who needs to buy what, the government has procurement under control.' [Donor]
...logistics system?	Yes	'From the financial point of view, we (NGO providing long-term procurement and logistics support) don't know when the government will be able to take over. But from the management point of view, the transfer...of activities, competencies and skills is underway. Starting next year, we will no longer have a direct intervention at peripheral (health center and district) levels. We will work only centrally and the government will take on district activities.' [NGO]
...Information and reporting systems (HMIS and LMIS)?	Mixed	<p>(Three stakeholders reported some anomalies between state and church health facilities.)</p> <ul style="list-style-type: none"> <li>• 'The secondary health posts capture information even if the church posts don't agree to [use the reporting forms]. But since church centers do give out CycleBeads, there is the risk of double-counting.' [MOH]</li> <li>• 'We have numbers but they are not sufficient. A good part of the information escapes us—information from the church structures. You have the SIS, which deals with service and user statistics. And then you have the LMIS. The one I'm referring to is the LMIS. Of course...you want to compare the two systems, to try to match the number of new users and the number of CycleBeads ordered or released from the central warehouse...We see the rhythm of consumption in the LMIS and it leads us to believe there is a surplus of CycleBeads, which isn't necessarily true.' [NGO]</li> <li>• 'The Catholic facilities...when they offer CycleBeads they do not use the same reports as the other facilities. They pass by the Caritas channel and receive supplies that they distribute via <i>éducatrices</i> in the Catholic system. But they don't...give information about what was given to clients and what is the quantity remaining. That is the information we are missing: everything that happens with these <i>éducatrices</i> and Catholic centers, because they don't report. They took a certain amount [of CycleBeads] about four years ago but we don't know what has happened. Do they not come back for more because they haven't given them all out? Are they resupplying from the health</li> </ul>

<b>Is SDM included in...</b>	<b>Respondents Consider Integration Complete</b>	<b>Context and Supporting Comments</b>
		<p>centers or district pharmacies? Have they stopped distributing? It escapes our control; it's what we don't know.' [NGO]</p> <p>(An equal number of stakeholders stated that the information systems are integrated.)</p> <ul style="list-style-type: none"> <li>• 'Whether public or church [health center], they use the same reporting form and reporting circuit. What we notice is that for CycleBeads, [the church facilities] report it, but for other methods there are some that won't even accept to use a reporting form with those methods on it. So in those cases, there is a secondary health post nearby that reports on it. No matter what kind of facility, all report on SDM.' [NGO]</li> <li>• Both FBO respondents stated 'yes,' the method is fully integrated into HMIS/reporting systems. [FBOs]</li> </ul>
...national health surveys?	Yes	Since 2005
...plans and budgets?	Yes	See procurement and logistics systems above
...awareness raising materials?	Yes	<p>'There are educational programs on FP, and materials are distributed. SDM is in there with other methods...every morning and evening, there are sketches on the radio' [NGO] [8]. 'We have a local drama group that has some very exciting talks on RH and FP. SDM is one of the topics they discuss. The radio [program] is covering not only Rwanda but Congo, Uganda, Tanzania and Burundi....100 percent of the population knows at least one FP method, and when you work at community level and ask people what <i>urunigi</i><sup>21</sup> is, they know it.' [MOH]</p>
...provider pre- and in-service training?	Yes	Also in supervisory tools

<sup>21</sup> A Kinyarwanda name for CycleBeads.

### 3.3.2 Provider Attitudes

Those who discussed their perceptions of provider attitudes towards SDM were unanimous: attitudes have changed for the better over time, and the majority of providers now respect SDM and give it the same weight as other methods when educating clients. One stakeholder's response was typical:

'Early on, providers doubted that it was effective, that women could learn to use it, or that men would accept the 12 days. But with time, attitudes have changed. If attitudes had not changed, it would have been a factor for failure. But we did not fail. So yes, attitudes changed, and in fact changed quite rapidly.' [NGO]

A public-sector stakeholder admitted that the FAM Project's midline evaluation—in particular, its use of mystery clients—highlighted service provider biases that were subsequently addressed. 'When the mystery clients came, the FP orientation and explanation were geared toward injectables or other so-called modern methods...Now, with further training [of service providers], SDM is a method like any other.' [MOH]

Of the respondents who discussed the *type* of provider best positioned to offer the method, all initially responded, 'nurses.' But upon consideration, they declared their confidence in community-based volunteers, whether the government-supported CHWs or the church-supported *éducatrices*.

### 3.3.3 Geographic Differences in Scale Up

When six interviewees were asked '*Do you think scale-up has been successful in some areas more than others,*' five stated that the method has been brought to geographic scale and is as likely to be available in one area as the next. 'I know that the product is available throughout the country, and is accepted like other methods. I know that women who want it can find it.' [NGO]

That said, all five of these respondents speculated on geographical differences either in the availability, acceptance or use of SDM, and posited that differences—if indeed there were any—might be attributable to provider skills and interest, the presence of state or church facilities, and rural or urban accessibility and preferences.

One respondent, however, cited *evidence* of geographical differences, notably that Rwanda's Western Province lags behind other parts of the country when it comes to FP use *overall*:

‘According to what we saw in the DHS 2010, we have some provinces which are performing very well, and others not very well. Northern Province, for example, is number one in FP. The last is Western Province. So we don’t have yet the explanation, the real reason for this disparity, this discrepancy in use of FP.’<sup>22</sup>

‘[However,] we have some tentative thinking about this. We know that in Western Province we have many health facilities managed by Catholic church. We know that some bishops do not support FP in general, even natural methods. So perhaps this is a reason...Also I think about the accessibility, the geographic accessibility: Western Province is mountainous. We don’t have a clear explanation...in the future I think we will have an assessment to see what is going on.’ [MOH]

Of interest, the six health districts of Western Province (and one in Eastern Province) were the last to extend SDM to all health facilities, achieving full coverage only in 2009.

### 3.4 Specific Questions Regarding SDM

#### 3.4.1 Advantages and disadvantages of SDM

The information here is drawn only from direct responses to the questions, ‘*What do you think are the benefits that SDM brings to RH/FP programs in your country? Does it also bring any disadvantages?*’ It does not include the many observations that interviewees made throughout the discussions on the benefits of SDM.

**Table 5: Advantages and Disadvantages of Adding SDM to FP Programs**

<b>Advantages</b>	<b>Number who Mentioned</b>
Permits greater involvement of men, is a couple’s method	4
Has no hormones, no side effects	3
Expanded the method mix, allows larger range of choice	3
Can be used regardless of religious beliefs	2
Is easy to use	2
Increases harmony among couples; increases household wellbeing, including economic	2
Is useful for involving and educating youth	1
Allows greater understanding of reproductive systems—for women, for couples	1
Is almost as effective as hormonal methods	1
Costs little	1
Contributes to service use at facilities	1
<b>Disadvantages</b>	<b>Number who Mentioned</b>
I see no disadvantages	7
As with condoms, the quantity you distribute is the quantity you think gets used, but you can’t be certain	1
May get left behind with government prioritization of long-acting and permanent methods	1

<sup>22</sup> This respondent clarifies, ‘It is not only for FP, but for many programs. We are seeing some districts, some provinces, that perform well in many programs, and but others that do not.’

### 3.4.2 SDM Scale Up and Rwanda's Church and State Health Systems

Given the importance of churches and church-run health centers in the Rwandan context, the topic of MOH/church collaboration permeated the interviews. Rather than allow stakeholders' observations to be scattered throughout this report and thereby lose their impact, the responses to several separate questions are collated and presented here.<sup>23</sup>

Respondents of all affiliations observed that SDM—a scientifically proven, modern method that is also a natural method—served as an important bridge or link between MOH and its NGO partners on one hand, and churches and their FBO partners on the other.

#### SDM from MOH/NGO point of view

MOH respondents unanimously expressed their relief that SDM gave the churches a reason to participate in FP service delivery and therefore the national FP policy. Said one:

‘When we call them [providers at church-run health facilities] to join a training now, they come. Before, they'd say, ‘with those [modern] methods, we won't attend.’ They were vexed; they did not want to hear us talk about pills and what not. But now they have the natural method they'd been looking for. Before, they saw themselves as excluded, but now they find themselves in the method mix, in the FP package.’ [MOH]

An NGO stakeholder is quoted (in 3.2.1.2) as saying that, within Rwanda's unique sociocultural environment, SDM arrived ‘like a godsend.’ The same respondent further discussed SDM's role as a catalyst for church leaders and followers. ‘With the innovation of SDM, it was like a drop that began to fill a pond that had been empty. And the [pond] filled quickly.’<sup>24</sup> [NGO] Another NGO respondent concurred: ‘Forty percent of the health facilities are Catholic, so other methods were not easy to introduce. This was an important factor that influenced SDM scale up.’ [NGO]

For these MOH and NGO stakeholders, then, the arrival of SDM in Rwanda jump-started the active role of church-run facilities in the national FP program.

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<sup>23</sup> Specifically, 3.2.b (*what external factors affected SDM scale up*), 3.2.b.4 (*how did IRH help /not help mediate these external factors*), and 3.4.b (*is SDM scale up an effective way to involve non-traditional organizations such as FBOs in FP*).

<sup>24</sup> This respondent means that the arrival of SDM (‘a drop’ of water) allowed the church (especially Catholic) to revitalize its offer of NFP services (‘the pond’) and in fact to renew its support for/actively promote NFP among its constituents.

### **SDM from Church/FBO point of view**

An FBO representative, meanwhile, acknowledged that the church's acceptance of SDM paved the way for his organization to advocate with church leaders to respond to pressure from the state to promote FP. Catholic Bishops convened and (as quoted in 3.2.2) created 'a clear policy for the dioceses, to say that now our NFP program will be done like thus and so,' and would actively promote SDM. The respondent continued:

'They [the Bishops] wrote instructions and sent them out [to] each health center...There had been pressure from the state to use modern methods, and we told them 'no'...[But] with the policy from the Bishops, we could show them the instructions and they understood and said, 'do your programs, and just make sure to show us the data.' The promotion of SDM has had a positive impact on the state's and other actors' knowledge of the church's role in FP. The most important change is that today the church health centers are no longer considered zeroes [in matters of FP] by the District Health Supervisors, as they were before.' [FBO]

### **IRH as collaborator, bridge between church and state**

Several respondents described IRH's professional, effective approach to interacting with church stakeholders and bringing them into the circle of key partners in SDM scale up. One NGO interviewee, involved since the AWARENESS project, summarized the arc of the collaboration:

'...I can say that the religious factor was in fact an opportunity. There was a great collaboration with religious leaders...Even those who did not want or did not understand, those who objected to any mention of barrier methods during the fertility period rather than abstinence...there eventually was consensus, all agreed and found mutual respect. I know that in certain sites, at certain moments...they said, 'no we will not offer this method.' But IRH sought and found solutions, pursued collaboration and negotiation until they understood the basis of the method, and the program could continue as planned. The [FAM] Project management really knew how to manage the various elements, opportunities, challenges, to bring the program to scale.' [NGO]

A donor representative reflected that the strong MOH structure was helpful to the scale up of SDM: '[Within] decentralization, the structures are clear and everyone knows their role. The method passed from policy, then into the health system in Rwanda.' However, she continued, individuals could still cause disruptions. 'I recall that at a certain moment the

bishop at Butare...said that SDM had to be stopped because it was a way of promoting condoms. So within a clear hierarchy, even if things are rosy, at a certain moment you can encounter obstacles like that one. But I know [IRH] held lots of advocacy meetings and was able to resolve it.' [Donor]

An FBO stakeholder listed the many ways that IRH supported and strengthened that organization's work in the field: 'At the level of awareness-raising, increasing motivation, integrating us as a partner, and training...we always did trainings together, both basic and in-service...The analysis of results, which we did together, and even field work. Then too, there is the climate of friendship that has prevailed.' [FBO]

In the sole negative note struck, the same stakeholder cited several ways that IRH's internal standards clashed with those of her FBO, including the pace of work, the pressure to produce results, and the technological divide between Washington, D.C., and rural Rwanda.

' We worked in a different framework where...what interested us most was not pressure to finish...but to see if something was done well and bore results. Sometimes they came and it was like, 'do this' or 'do that.' They imposed. Western countries have their own mentality, way of doing things. They don't understand local sustainability. We need to talk more of cultural appreciation. For us, quality counts.' [FBO]

It may be worth noting that this respondent emphasized several times that her FBO engaged with SDM not as a reproductive health intervention, but as a tool for social development.

### **3.5 Next Steps and Interviewees' Recommendations**

Finally, all interviewees were asked two linked questions: What is needed to complete SDM scale up in your country? What is needed to sustain what has been achieved?

While all respondents considered SDM scale up to be near-complete, they also were able to identify several actions or inputs that would solidify SDM's permanent place in Rwanda's FP program. Responses below are categorized by the level at which the suggested steps should take place or by the suggested steps' general topic. That said, some suggestions were clearly directed at IRH.

## **IRH**

- Strong transition period to ensure full transfer of capacity, especially to district trainers
- Extend FAM Project for several years to solidify gains, especially CHW role as FP providers
- Extend FAM Project to provide more, longer grants for social marketing

## **GoR/MOH: National and District Levels**

- Post-scale up strategies to maintain achievements (ongoing training, supportive supervision of service providers and district trainers; consistent supply of training materials).
- As GoR takes on financing of FP methods, and if GoR finds it can't afford all methods, ensure that CycleBeads don't get de-listed in favor of more popular methods.

## **GoR/MOH: Community Level**

- Increase community education efforts.
- Deploy special strategies to educate special groups (youth, women's associations, etc.)
- 'Anchor' CHW's new FP work with follow-up, monitoring.
- Add 'focal point' type of role to CHW network; focal points would be qualified to distribute (rather than only counsel and refer) CycleBeads in communities.
- Locate current users of other NFP methods and orient them towards SDM.

## **Catholic Church: National and Diocese Levels**

- Post-scale up strategies to maintain achievements (ongoing training, supportive supervision of service providers and district trainers; consistent supply of training materials).

## **Research and Knowledge Sharing**

- Determine the real role of SDM in fertility reduction, use of SDM by those who state they are condom users.
- Investigate (and fill) information gaps in the HMIS and LMIS (especially data emanating from church-run facilities).
- Organize knowledge sharing with other (especially African) countries on integration, use of SDM.

## **Other**

- Advocate that all references to SDM as a (or grouped with other) "traditional methods" be redacted in curricula, protocols, norms, etcetera, and that SDM consistently be presented as a modern, scientifically proven FP method.
- Make sure no imitation CycleBeads slip onto market.