

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

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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

APROFAM	<i>Asociación Probienestar de la Familia</i> /Association for Family Well-Being
APROVIME	<i>Asociación ProSalud Preventiva para la Mujer Vivamos Mejor</i> / Association for Preventative Health for Women to Live Better
CHW	Community Health Worker
CNAA	<i>Comisión Nacional de Aseguramiento de Anticonceptivos</i> /National Commission on Contraceptive Security
CRS	Catholic Relief Services
DECAP	<i>Departamento de Capacitación</i> / MOH Training Department
ENSMI	<i>Encuesta Nacional de Salud Materno Infantil</i> /National Survey of Maternal & Child Health
FBO	Faith-Based Organization
FESIRGUA	<i>Federación de Salud Infantil y Reproductiva de Guatemala</i> /Reproductive & Child Health Federation of Guatemala
FGER	<i>Federación Guatemalteca de Escuelas Radiofónicas</i> /Guatemalan Federation of Radio Schools
FP	Family Planning
HMIS	Health Management Information System
IEC	Information, Education, and Communication
IGSS	<i>Instituto Guatemalteco de Seguridad Social</i> /Guatemalan Social Security Institute
IRH	Georgetown University Institute for Reproductive Health
KIT	Knowledge Improvement Tool
LAM	Lactational Amenorrhea Method
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MSC	Most Significant Change
NGO	Non-Governmental Organization
PEC	<i>Programa Extensión de Cobertura</i> /MOH Extension Program
PNSR	<i>Programa Nacional de Salud Reproductiva</i> /National Reproductive Health Program
PSI	Population Services International
PROEDUSA	<i>Promoción y Educación en Salud</i> /MOH Health Promotion and Education Program
SDM	Standard Days Method
SDP	Service Delivery Point
SIAS	<i>Sistema Integral de Atención en Salud</i> /Integral Health Care System
SRH	Sexual and Reproductive Health
TA	Technical Assistance
UPI	<i>Unidad de Atención a los Pueblos Indígenas</i> /Indigenous Peoples' Unit
UNFPA	United Nations Population Fund
URC	University Research Corporation
USAID	United States Agency for International Development
USME	<i>Unidad de Supervisión, Monitoreo y Evaluación</i> /MOH Supervision, Monitoring and Evaluation Unit
WHO	World Health Organization

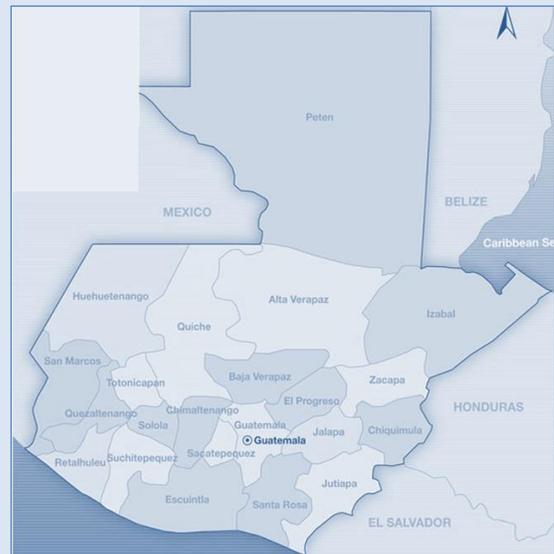
## Executive Summary

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 the Democratic Republic of Congo, Guatemala, India, Mali, and Rwanda.

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

The Ministry of Health (MOH) is the largest health service provider in Guatemala, followed by the Social Security Institute (IGSS) and the NGO, APROFAM. The MOH's third-tier facilities are typically found in remote, rural areas and staffed by trained community volunteers, an auxiliary nurse and perhaps a rural health technician. Second-tier facilities are health centers offering mostly outpatient services, while first-tier facilities are regional and national hospitals. Access to services remains a significant problem for the rural poor, although the government has made progress via a special program designed to reduce disparities in health services and outcomes between ladino and indigenous Guatemalans.

The government of Guatemala has supported family planning programming for about three decades, and the overall contraceptive prevalence rate, for all methods, among women of reproductive age is currently 54%. However, there are a variety of factors, including politics, cultural diversity, and religion, which influence access to and use of family planning in the country. For example, the Catholic Church exerts a strong political influence and has opposed enactment of the *Law on Universal and Equal Access to Family Planning Services*. Given the church's preference for natural methods of family planning, the institution's clout would be expected to create an enabling environment for SDM integration. However, certain sectors of the Catholic Church oppose SDM because it is not based on checking physical signs of fertility and promotes the use of a barrier method during fertile days. On the other hand, certain cultural factors facilitated SDM scale-up in the



## GUATEMALA AT-A-GLANCE

<b>CURRENT POPULATION:</b>	14.7 million
<b>POPULATION GROWTH RATE:</b>	2.52% per year
<b>GDP PER CAPITA, 2012:</b>	\$3,178
<b>INDIGENOUS POPULATION:</b>	41%
<b>INDIGENOUS POPULATION BELOW POVERTY LINE:</b>	74%
<b>TOTAL FERTILITY RATE:</b>	3.9
<b>CONTRACEPTIVE PREVALENCE, WOMEN AGES 15-49, 2009:</b>	54.1%
<b>MATERNAL MORTALITY RATIO PER 100,000 LIVE BIRTHS:</b>	140
<b>INFANT MORTALITY RATE PER 1,000 LIVE BIRTHS:</b>	24.2

Sources: World Bank World Development Indicators, Guatemala DHS

country. Some Mayan cultures believe that foreign items such as modern contraceptive methods upset the spirit-body balance and can cause ill health, and see SDM as a family planning method that is acceptable.

## Introductory Phase 2002-2007

Among its first steps in Guatemala, IRH established the evidence-base for integrating SDM and ensured its inclusion in the national norms. IRH then worked with USAID partners, the MOH and local NGOs to integrate SDM into public and private sector FP services in five departments (of 22 total in Guatemala) that are home to rural, indigenous populations.

IRH set several objectives for its pilot phase in Guatemala, noted below with information about their achievement:

- *Integrate SDM into public and private programs and ensure quality services.* With SDM securely included in national norms, IRH worked with the public and private sectors (including NGOs and FBOs) to build capacity for SDM counseling, raise awareness of the method, and strengthen service provision through research. IRH and USAID partners developed SDM training and IEC materials; these and several other NGOs then conducted SDM training for the MOH, IGSS and still other NGOs that provided FP services.
- *Test/document various strategies for provision.* At the MOH's request, and based on its concern that CycleBeads®' cost would discourage potential users, IRH developed a paper image of CycleBeads. Use of the paper image was compared to use of actual CycleBeads with 600 SDM users and 90 providers over 18 months. Users and providers preferred the real beads, though users performed equally well with the paper version.
- *Develop and test a cost-effective, distance learning module.* IRH created a distance-learning module with two formats (online and self-study), tested it with 120 auxiliary nurses, and found that both formats were acceptable and effective.
- *Evaluate cost-effectiveness of the Knowledge Improvement Tool (KIT) as a supervision tool.* In Guatemala, IRH found that KIT was most cost-effective when used in a group (rather than one-on-one) to reinforce provider knowledge of SDM.
- *Include SDM in nurse and auxiliary nurse pre-service training.* IRH succeeded in introducing SDM into the training curricula of MOH nursing programs. At the close of the pilot phase in 2007, SDM was embedded in national FP norms, and some headway had been made to include the method in national management information and logistics systems, pre- and in-service training, and communication strategies. About 200 trainers and 2,000 providers knew how to offer the method.

### PILOT PHASE ACHIEVEMENTS

- SDM integrated into public and private programs in five departments
- Strategies for SDM provision were tested; users and providers preferred physical CycleBeads to a paper version
- A cost-effective distance learning module was developed and tested
- The Knowledge Improvement Tool (KIT) was found to be an effective supervision tool
- SDM was included in the training curricula of MOH nursing programs

## HOW SUCCESSFUL WAS SCALE-UP OF SDM IN GUATEMALA?

As of December 2012:

### SERVICE EXPANSION

SDM services are available in 305 service delivery points in the three scale-up departments

Fourteen organizations have the capacity to train, deliver services or lend technical assistance on SDM

### INSTITUTIONALIZATION

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

- Norms, policies, guidelines
- Pre-service and in-service training curricula
- Logistics systems
- MIS reporting systems

### SDM USERS & KNOWLEDGE OF SDM OPTION

35.2% of women in the scale-up departments had heard of SDM at *endline*.

SDM users comprised about 2.3% of all FP users at *endline*.

Primary reasons former users stopped using SDM included becoming pregnant or wanting to become pregnant.

## Scale-Up Phase 2007-2012

IRH officially launched SDM scale-up in late 2007. More than 60 stakeholders from the public, private and donor sectors joined IRH to develop, over the course of several meetings, a Guatemala-specific scale-up strategy. The ExpandNet framework was introduced as a guide for both setting and implementing the strategy. The goal of the five year project was to demonstrate whether SDM could be offered at scale in three departments. Combined with advocacy efforts, the evidence generated by this initiative could serve to guide decision-makers regarding the role of SDM in FP services, and that efforts to expand access to SDM at the national level would benefit the Guatemalan population and broaden options within the FP program.

Following the ExpandNet framework, the Resource Team, under the direction of IRH and the MOH's National Reproductive Health Program (PNSR), was formed to ensure the integration of SDM in the work of resource and user organizations. Key elements of the strategy used in Guatemala focused on:

- a) Working in collaboration with public and private organizations that provide FP services, and
- b) Building capacity to establish a cadre of trainers, from nurses to community volunteers, to be able to offer SDM
- c) Ensuring SDM is tracked properly in reporting systems.

Scale-up focused geographically on Quetzaltenango, Sololá, and Santa Rosa, and efforts were made to ensure community-based (non-clinical) provision and a robust IEC component.

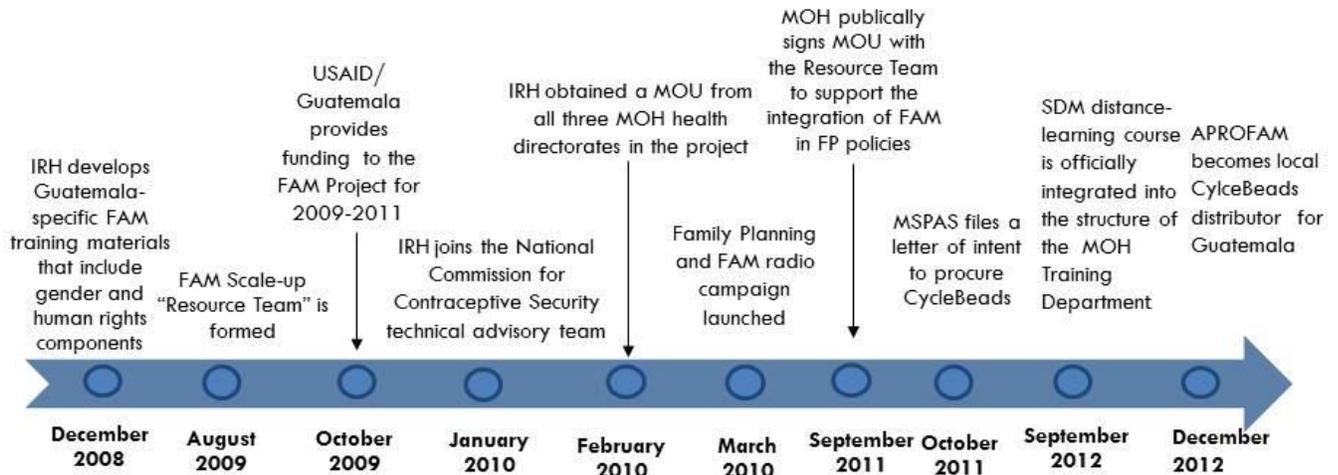
IRH staff in Guatemala included a Country Representative and one expert each in: IEC/Communications; Training; Research/M&E; and Finance/ Administration to facilitate the scale-up of SDM.

### Using Data to Guide Scale-Up

In Guatemala, IRH collected both primary and secondary information to guide SDM scale-up and assess progress. A *baseline* in 2010 consisted of an assessment of service delivery points, interviews with providers including CHWs, and a household survey with women and men. This multi-part assessment was repeated at *endline* in 2012 (see discussion of results below).

IRH also conducted *stakeholder interviews* in 2009 and 2011 to collect and analyze a range of views on FP and SDM in Guatemala's political and social environment, on scale-up progress, and on remaining tasks to ensure that SDM is sustained within the national FP framework. Stakeholders included representatives of communities and of organizations that provided FP services, established national guidelines, safeguarded women's rights, and/or funded FP and other health programs in Guatemala.

IRH maintained a graphic *events timeline* (see a condensed version below), which highlighted both project and political events and achievements from 2002 through 2012. The *Most Significant Change* M&E methodology was used by partner organizations in 2011-2012 to gain new perspectives on the scale-up experience from points of view that included those of users, providers, policy makers, and program managers.



**Awareness and Use:** The endline assessment showed change since baseline in women’s and men’s awareness and use of SDM and other FP methods, and in SDM availability and service quality. IRH found that women had a greater *overall* awareness of FP methods at endline, as well as significantly greater specific awareness of SDM. However, though awareness of SDM had increased, it was still lower than awareness of other FP options. The endline reported change in awareness of only a few of the 16 FP methods included in the survey tool. At both baseline and endline, 54% of women thought SDM was a difficult method to understand. However, 50% thought it was an effective method, compared to 41% at baseline, and 77% believed it is economical, compared to 67% at baseline. Significantly fewer women at endline than at baseline thought it had side effects or caused health problems.

At baseline, only one survey respondent was using SDM, but at endline 2.3% of women practicing FP reported current use. The proportion is small, but represents an important gain in the two years between assessments, especially given the fact that only 35% of women had ever heard of the method. Overall, 72% of female respondents at endline claimed current use of a method. Most common among women using a FP method were injectable and female sterilization (41.1% and 35.3%); at 2.3 %, SDM was similar to IUD and implant (at 2.9% each) but lagged behind pill and condoms (6.1% and 5.2% respectively). Important percentages of women still report use of rhythm (9.3%) and withdrawal (8.2%), suggesting that SDM services are still not reaching many who need them.

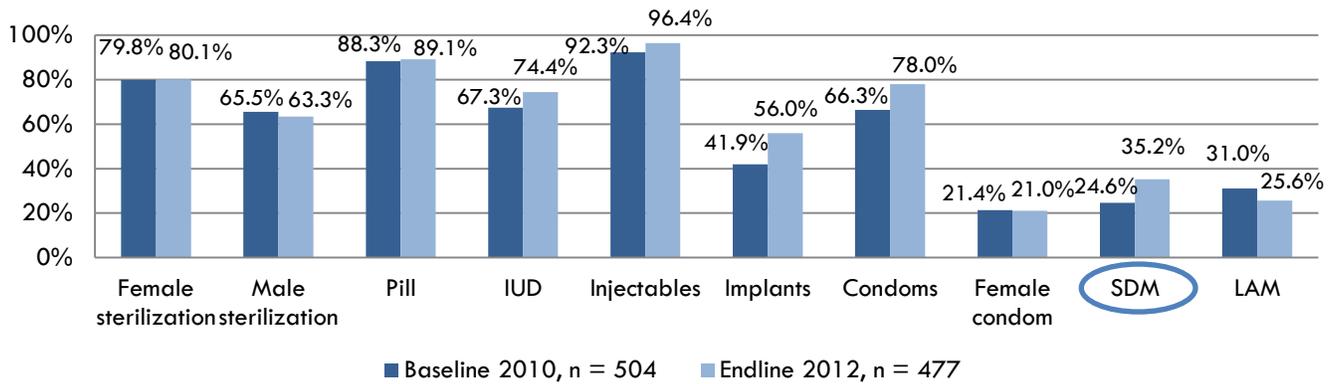
**IN GUATEMALA,  
IRH & THE FP  
RESOURCE TEAM  
DEFINED THE SDM  
INNOVATION  
PACKAGE AS:**

A modern, natural FP method available in all services that:

- attracts potential new users,
- facilitates understanding of how contraceptives work by providing a basic knowledge of the menstrual cycle,
- helps overturn myths and misperceptions about FP,
- helps women make decisions to take control of their bodies, and
- facilitates positive male involvement.

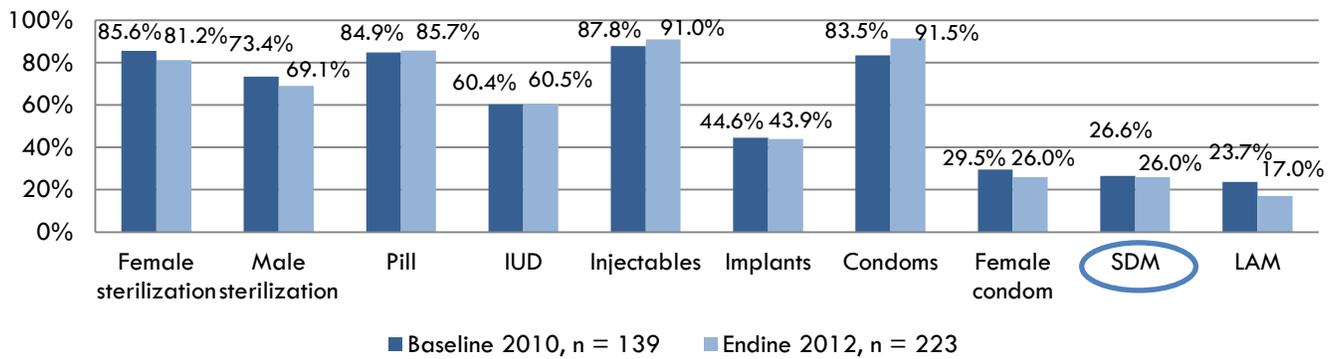
## PERCENTAGE OF WOMEN WHO KNEW OF FAMILY PLANNING METHODS

### IRH Household Surveys



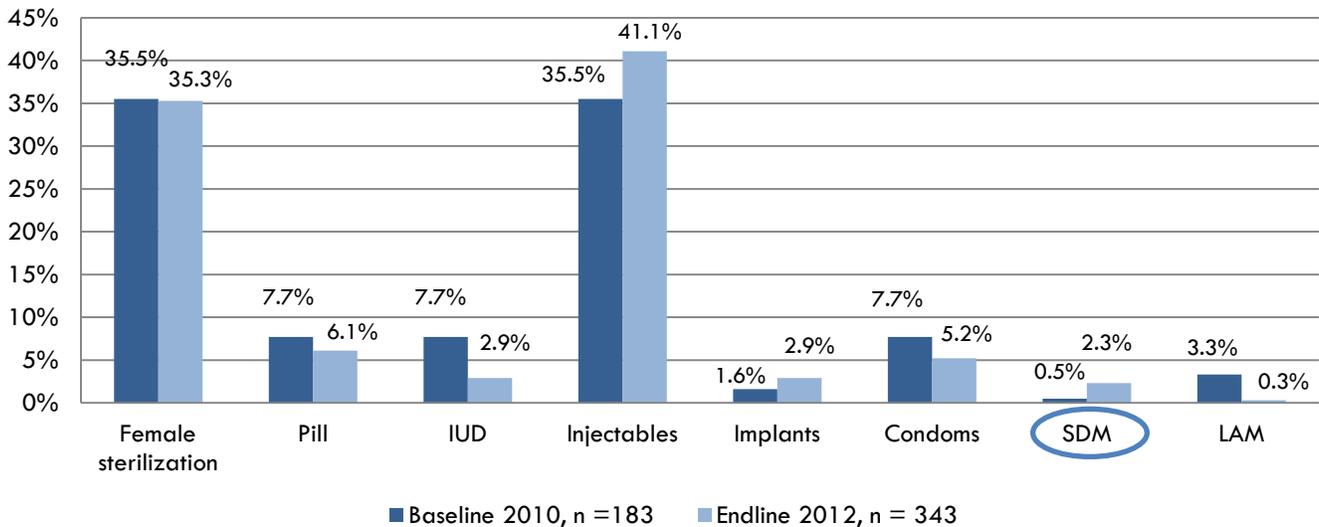
## PERCENTAGE OF MEN WHO KNEW OF FAMILY PLANNING METHODS

### IRH Household Surveys



## METHOD USE AMONG WOMEN CURRENTLY PRACTICING FAMILY PLANNING

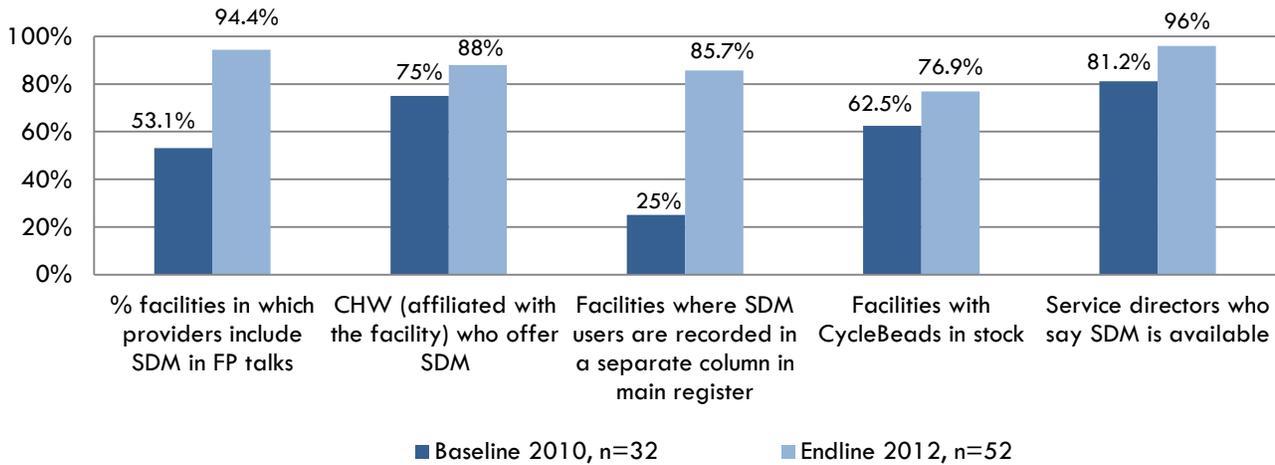
### IRH Household Surveys



Male sterilization, female condoms, and traditional methods use were each less than 1.1% at both baseline and endline. Rhythm and withdrawal not shown.

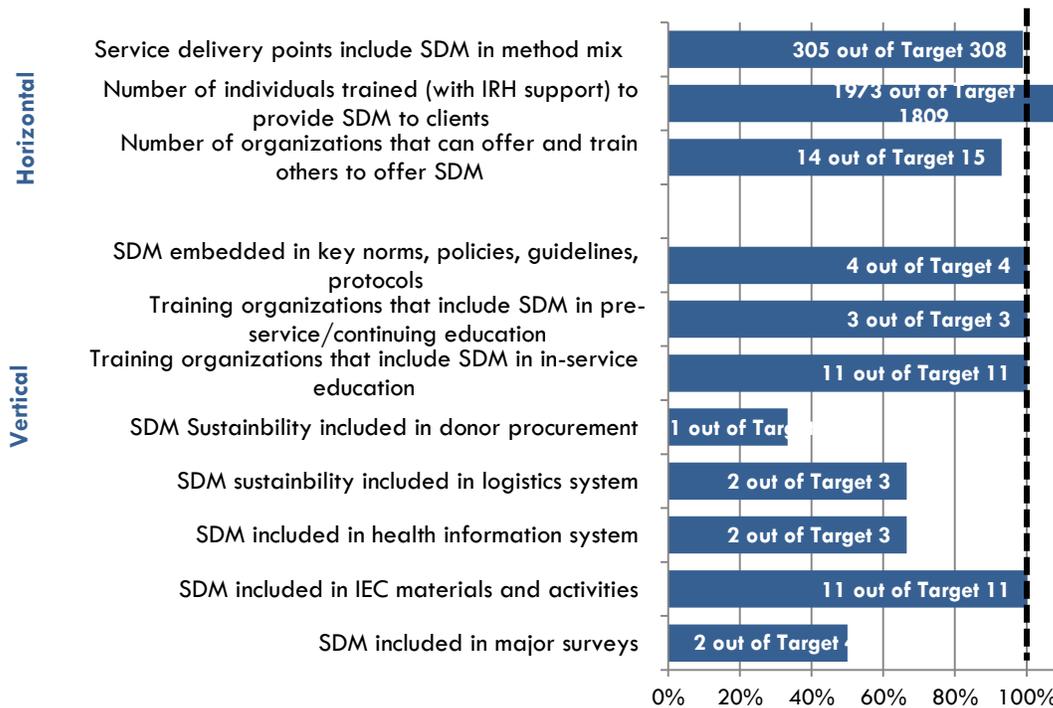
**Availability and Provider Performance:** The endline found that SDM availability had increased in all areas surveyed, as had all direct measures of service provision. The chart below shows selected endline results on service provision.

### SELECTED SERVICE PROVISION RESULTS IRH Facility Surveys



### Achievement of SDM Benchmark Targets

#### PROPORTION OF BENCHMARKS ACHIEVED, GUATEMALA



In Guatemala, as in all other countries where SDM was scaled up, the Resource Team developed a set of benchmark indicators, and made regular use of data from public and private service providers and from other sources to track progress against targets. The graphic above shows overall achievement of those targets in Guatemala.

The ExpandNet framework includes elements of both horizontal and vertical expansion. Work along the *horizontal scale* increased availability of and provider capacity to offer SDM in the three departments where scale-up was focused. By the end of 2012, 305 service delivery points included SDM in their method mix (99% of target), and nearly 2,000 individuals (109% of target) were trained to counsel clients in SDM. Fourteen organizations had the capacity to train others to offer SDM.

**According to MOH and APROFAM facility statistics, 3,175 women accepted SDM over the course of the scale-up phase.**

Activities on the *vertical scale* aimed for SDM's sustainable institutionalization in Guatemala's FP method mix and service standards. SDM was included in the MOH's national RH norms and its FP guidelines, in IGSS' FP norms, and in APROFAM's clinical protocol—the four standard documents that IRH identified as essential at the start of the scale-up phase. Having included SDM in these documents, the organizations could then include SDM in their training, IEC and service delivery activities, and in their information systems. SDM was also

included in all of the pre- and/or in-service training programs targeted by IRH.

SDM's sustainable inclusion in donor procurement and logistics systems proved difficult. The MOH requested procurement of CycleBeads in 2011, but UNFPA (which is responsible for contraceptive purchasing for the country) denied the request, stating that 'CycleBeads are not included in the essential medicines list issued by WHO.' In 2013, UNFPA finally established an agreement with Cycle Technologies, the manufacturer and distributor of CycleBeads, to procure the commodity for countries that earmark their own funds for purchases through the AccessRH mechanism. However, after a second request was made by the MOH, UNFPA/Guatemala still declined to procure CycleBeads stating that the quantity requested (5,000) was too low in spite of the fact that their agreement with the manufacturer detailed a minimum purchase amount of 500. IRH therefore developed an agreement with APROFAM to enable the latter to serve as distributor of CycleBeads in Guatemala, creating a revolving fund from the sale of commodities to purchase additional commodities. The MOH could then buy CycleBeads from APROFAM in country. IRH also encountered difficulties embedding SDM in major surveys as planned. The method will be included in the next DHS in Guatemala, one of four surveys targeted by IRH.

Finally, IRH was able to determine, using MOH and APROFAM facility records and service statistics, that 3,175 women in the selected geographic settings accepted SDM over the course of the scale-up phase.

## Scale-Up and the Guatemala Environment

As a whole, the environment in Guatemala during scale-up was stable and even somewhat favorable to SDM and FP programs. The MOH's PNSR was IRH's main scale-up partner, followed by IGSS and APROFAM. IRH also worked closely with national networks of FP and SRH organizations. The state approved regulations in 2009 to operationalize its *Law on Universal and Equal Access to FP Services*, including establishment of a tax on alcohol sales to fund SRH programs. This was a significant step on a long road, and it was a key factor in the MOH's choice to integrate SDM into its contraceptive procurement plans. Elsewhere on the political front, leadership positions in the MOH and APROFAM changed several times during the scale-up phase; IRH devoted additional time and resources as needed to advocate with new leaders. The IGSS' FP service delivery was suspended during much of the scale-up phase, though it intends to resume shortly.



IRH's stakeholder interviews confirmed the general view that the MOH must be the national leader in FP, including their leadership in SDM integration after 2012 when the scale-up phase ended. The MOH accepted this role and confirmed its responsibility to promote all methods equally, without bias. IRH ensured that MOH, and especially PNSR, representatives participated in key planning and research activities. An overall lack of resources in the MOH budget, including in its FP program, suggests that future SDM integration and scale-up may be challenging.

Political and religious environments are closely linked in Guatemala. As noted, the Catholic Church opposed the *Law on Universal and Equal Access to FP Services*. IRH made explicit efforts to advocate for SDM's acceptance by various church actors. A Catholic university and two FBOs (CRS and Caritas) were interested in integrating SDM in their curricula or services, they were unable to gain permission from the church.

USAID in Guatemala provided direct funding to IRH for the first two years of scale-up, then allocated its FP support budget to several new, bilateral health programs. IRH continued activities with funds from USAID's central grant to IRH in Washington, D.C., and following USAID's request, attempted to collaborate with its large-scale, bilateral health programs. However, some of the implementing agencies showed little interest. Meanwhile, UNFPA did not respond to either of the MOH's explicit wishes to procure CycleBeads, in spite of UNFPA headquarters' decision to add them to its commodity catalog.

## Resource and User Organizations

The strategy-setting workshops for the scale-up phase resulted, among other things, in the formation of a Resource Team whose membership included several representatives of the MOH (PNSR and other divisions), IGSS, APROFAM, several NGOs, and networks of organizations that provided services, raised awareness and safeguarded rights. These institutions identified a potential to incorporate SDM into their activities, and worked on SDM integration and advocacy through their organizations and networks. Over time, their work centered on the emerging theme of 'community-based FP services' in a country where FP had been focused solely on facility-based health services. The Resource Team grew to consider itself an inter-institutional board with operational interventions, designed to bring FP to the community in a systematic manner, in part by identifying local Resource Teams (one in each focus department) that both implemented and collaborated with the central FP Resource Team.

Women's empowerment, male involvement, and couple communication are intrinsic characteristics of SDM and were emphasized throughout the scale-up process. Through integration of the SDM in its FP program, the MOH was able to accomplish its goal of incorporating cross-cutting issues such as sexual and reproductive rights, gender and sexuality.

As the official scale-up phase drew to a close in late 2012, IRH and the MOH drew up plans to transition key activities (in advocacy, capacity-building, IEC, logistics and procurement) to members of the Resource Team.

User organizations in Guatemala included an array of NGOs that were members of the MOH-organized network of extension workers. More than a dozen such organizations received training and technical assistance to offer SDM to clients. However, unlike major service delivery organizations (and members of the Resource Team) MOH, IGSS and APROFAM, these NGOs were more likely to suffer serious capacity deficits when there was staff turnover. And, because they received CycleBeads directly from IRH, their future supply pipeline was less certain.

In sum, MOH and APROFAM have both the greatest capacity and likelihood to sustain SDM services in the future. Of note, the MOH is mandated to do so, but APROFAM is likely to base its provision of SDM services on demand for CycleBeads because it is a private, self-sufficient organization which relies on revenue generation for its success.

In IRH's analysis, several incentives may favor ongoing integration or sustainability of SDM in the FP method mix. First, the MOH embedded the method in several key protocols which mandated that the method be offered. Guatemala also hosts several watchdog organizations that monitor the availability and quality of health services, including a range of FP methods, as stipulated by law.

## Strategic Choice Areas

### Capacity Building and Technical Assistance:

In addition to including SDM in general FP training, using a training-of-trainers approach, and applying the supervision checklist (KIT) as both an assessment tool and an opportunity to detect and fill gaps in provider capacity, IRH notes several other ways it contributed to capacity building in Guatemala.

*Strategy for Training Traditional Birth Attendants.* A large proportion of rural, indigenous Guatemalans do not live near even a third-tier health post, and have no access to clinic-based FP services. Using standards set forth in MOH's own national FP Guidelines, IRH provided technical assistance to PNSR in the design, implementation and evaluation of a strategy that authorized traditional birth attendants (TBAs) to provide selected contraceptives and counseling at the community level. This initiative was implemented on a small scale in Quetzaltenango (53 TBAs and 15 facilitators) and Santa Rosa (32 TBAs, seven facilitators). To evaluate effectiveness of the training, IRH used the KIT and found that 76% of traditional birth attendants could provide correct initial counseling for the pill, as could 54% for SDM. Using service statistics for a period of nine months prior to the intervention and the nine-month period of the intervention, a moderate increase in FP users during the intervention period was seen.

*Engaging Educational Institutions.* In 2010, IRH undertook a survey of seven educational institutions for health care providers, to determine the quality and effectiveness of pre-service FP training, including SDM. These schools for auxiliary nurses and rural health technicians had incorporated FP and SDM training, and IRH found that auxiliary nurses' training positioned them to best provide FP in both the community and the health service setting. IRH then worked to include SDM in nurses' pre-service training at 10 additional nursing schools in Guatemala. IRH also developed a distance-learning module on SDM, in two formats: self-study and online. The MOH's training department reported certifying more than 200 providers of various types via these modules. The online course forms part of the MOH platform, while the self-study course has been offered in departments outside of the three FAM focus departments through the MOH's Training Department.

**IRH developed an SDM distance learning module that is available both as a self-study course and online.**

**Advocacy:** IRH participated in relevant meetings and networks to promote inclusion of SDM and to disseminate the results of scale-up and research. IRH generated opportunities for partners and engaged them in the scale-up process, which encouraged partners to become more involved in and eventually take ownership of some components of scale-up. The FP Resource Team, coordinated by PNSR, played a critical role in advocacy. The Resource Team successfully advocated to include CycleBeads on MOH procurement lists and to enable TBAs to offer condoms, pills, CycleBeads and LAM at community level for the first time in Guatemala. PNSR advocated to make the Resource Team's existence official within the MOH system, and contributed resources for the interventions and monitoring activities that the team undertook. PNSR also ensured financing for the MOH to purchase CycleBeads supplies through the government open contract system.

**Demand Creation:** An IRH assessment found that health providers in charge of promotion had little specific training or materials with which to do their jobs, and missed many opportunities to reach men and women with information. IRH designed a guide for training health promoters which included theoretical and practical portions. Training focused on ways of bringing FP and SDM information to the population. IRH worked with local NGOs on community and mass media FP awareness raising activities.

**Monitoring & Evaluation:** The MOH had several health data collection tools, but none was specific to FP. Moreover, user organizations tended to have weak M&E systems. PNSR identified the need for standardized M&E instruments for FP programs; prototypes of a logistics and a quality assurance tool were developed by PNSR and reviewed by the Resource Team. The instruments are considered official tools and will soon be disseminated through the MOH for implementation.

**Resource Mobilization:** Since the SDM introductory phase, the MOH, along with other partners, contributed financial resources for SDM integration by way of cost-sharing. However, continued resource mobilization for SDM integration and scale-up will be difficult due to an overall lack of resources in national budgets, including the RH program.

## Key Elements that Facilitated Scale-Up in Guatemala

The scale-up efforts carried out by IRH and its partners carried out in Guatemala were substantial, and endline results and benchmarks show important achievements. IRH notes several factors in the operating context that supported both activities and successes.

1. Partners, and especially PNSR, were involved in defining the innovation and designing the scale-up strategy. The buy-in generated in these earliest days was valuable throughout the scale-up phase. Not only did partners join in the advocacy for SDM integration (into new materials, guidelines, capacity-building activities, etc.), they took shared responsibility for the outcome. These results were achieved by an Inter-institutional Resource Team over the course of more than three years.
2. A weak public-sector M&E system meant that IRH had to lead efforts to monitor the progress and quality of SDM integration. But joint activities, such as M&E visits and capacity-building activities, allowed the MOH to identify gaps and take strides to improve the system. One of the lessons learned was the critical and complementary role the M&E process can play in systems strengthening. Working to identify and address existing gaps improves both an individual program's success as well as the system as a whole.
3. The government of Guatemala managed several programs designed to reduce the marginalization of indigenous populations, and this commitment ultimately supported IRH and partner advocacy to

expand access to FP and SDM. IRH’s intervention, in which traditional birth attendants were trained to distribute certain methods in the community, was an opportunity to bring FP services out of the clinic and into the community. Results from this pilot study were largely positive; however, the intervention would need to be expanded to make a measurable impact.

4. The *Law on Universal Access to FP Services* created a dialogue in Guatemala about the importance of informed choice, and energized women’s organizations, including several on the Resource Team, to demand inclusion of all methods, including SDM, in FP services.

## Sustainability of SDM in Guatemala

Significant progress has been made across the various components of scaling up SDM at the national level. To assure that these achievements are sustained and/or advanced upon the end of the FAM project, however, there is a need to identify key actors and strategies that will move SDM forward in terms of advocacy, capacity building, logistics and procurement, IEC, and HMIS and M&E.

SCALE-UP COMPONENT	ACTION FOR SUSTAINABILITY	RESPONSIBLE PARTY
ADVOCACY	<ul style="list-style-type: none"> <li>• Advocate for inclusion of FAM as new materials are developed and guidelines, protocols and surveys are updated.</li> <li>• Incorporate the SDM Integration Toolkit under the MOH website.</li> </ul>	<p>Resource Team</p> <p>MOH National SRH Program</p>
CAPACITY BUILDING	<ul style="list-style-type: none"> <li>• Maintain resources and provide technical assistance to expand SDM capacity building activities nationally.</li> <li>• Maintain SDM online course on MOH website.</li> </ul>	<p>Resource Team organizations</p> <p>MOH Training Department</p>
LOGISTICS AND PROCUREMENT	<ul style="list-style-type: none"> <li>• Support CycleBeads distribution in the public and private sectors.</li> <li>• Distribute procurement information via AccessRH.</li> </ul>	<p>APROFAM</p> <p>MOH, UNFPA</p>
IEC	<ul style="list-style-type: none"> <li>• Use and incorporate SDM IEC resources (e.g. radio programs, invitation cards etc.) into project activities.</li> </ul>	<p>USAID bilateral members</p> <p>MOH National SRH Program</p>

**HMIS/  
MONITORING &  
EVALUATION**

- Institutionalize FP M&E supplemental instrument developed by the Resource Team, with support from IRH.
- Provide financial assistance for M&E visits to public/private health posts.
- Conduct M&E visits to public and private sector health post.
- Include SDM in 2014 DHS.

MOH National SRH Program

Resource Team

USAID bilateral members

USAID/Guatemala Mission

## Introduction

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

This report presents SDM scale-up efforts in Guatemala, including strategic choices, implementation activities, and results. It concludes with an analysis of factors that influenced scale-up and a call to action to the Ministry of Health (MOH) and partners to continue the scale-up work begun by IRH.

## Background

Guatemala, the largest country in Central America, is home to almost 15 million people, 59 percent of whom identify as *mestizo* or of European descent. Among the 41 percent of Mayan descent, 21 Mayan groups are represented, and 26 Mayan languages are currently spoken in the country. About 51 percent of Guatemalans live in rural areas. Indigenous groups are mostly concentrated in small farming communities in the Western Highlands.<sup>1</sup> More than half the population lives below the national poverty line, but poverty among people of Mayan descent averages 76 percent. Furthermore, 43 percent of children under age five are chronically malnourished, one of the highest malnutrition rates in the world.<sup>2</sup>

Given these circumstances, the level of interest in improving access to FP in Guatemala is high. Despite more than 30 years of FP programming, contraceptive prevalence remains relatively low, at 54 percent of women aged 15–49. It is lower still among rural (46 percent) and indigenous women (40 percent).<sup>3</sup> Of women who use any FP method, 10 percent practice some form of periodic abstinence although no more than 25 percent could identify the midpoint of the cycle as the time of greatest risk of pregnancy.<sup>4</sup> In this context, integration of the Standard Days Method® (SDM), a fertility awareness-based method (FAM) that helps women track their menstrual



### GUATEMALA AT-A-GLANCE

<b>CURRENT POPULATION:</b>	14.7 million
<b>POPULATION GROWTH RATE:</b>	2.52% per year
<b>GDP PER CAPITA, 2012:</b>	\$3,178
<b>INDIGENOUS POPULATION:</b>	41%
<b>INDIGENOUS POPULATION BELOW POVERTY LINE:</b>	74%
<b>TOTAL FERTILITY RATE:</b>	3.9
<b>CONTRACEPTIVE PREVALENCE, WOMEN AGES 15-49, 2009:</b>	54.1%
<b>MATERNAL MORTALITY RATIO PER 100,000 LIVE BIRTHS:</b>	140
<b>INFANT MORTALITY RATE PER 1,000 LIVE BIRTHS:</b>	24.2

Sources: World Bank World Development Indicators, Guatemala DHS

cycles and identify their fertile days, would appear a promising strategy. SDM integration was also deemed favorable because several studies showed that Mayan women in Guatemala prefer natural methods.<sup>5</sup>

In 1998, a simple calendar rhythm method was tested among mostly Mayan couples in the Guatemalan highlands. APROVIME, a local non-governmental organization (NGO) carried out the study with technical assistance (TA) from the Population Council. The study required couples to track the woman's menstrual cycle using a calendar and a necklace as a reminder and to abstain from intercourse on days 9-19 of each cycle. Couples reported being satisfied with the method and effectiveness and continuation rates were high. The study further demonstrated the potential of offering a simple natural method among the Mayan in Guatemala.<sup>6</sup>

In Guatemala, the three main providers of sexual and reproductive health (SRH) services are the MOH; the International Planned Parenthood Federation affiliate - APROFAM; and the Guatemalan Social Security Institute (IGSS). The MOH provides free SRH services and commodities throughout the country. APROFAM is a national private sector organization that provides services and commodities at a cost; IGSS works through employer-operated clinics to provide services for employees, but in recent years has only provided maternal and child health and not FP services. Also important is that donor support for FP commodities and contraceptive security is limited; the United States Agency for International Development (USAID) no longer procures contraceptives for public sector use in Guatemala. The MOH must budget for and procure commodities and does so mostly through the United Nations Population Fund (UNFPA), which sells commodities at a reduced price. As will be seen, these structural and institutional factors have had an important influence on scale up of SDM. Regardless of these different options to access FP, availability of services and commodities remains limited, especially for indigenous men and women in rural areas.

### **Pilot Phase, 2002-2007**

In 2002, when IRH introduced SDM and its visual aid CycleBeads®, a color-coded string of beads that helps identify the fertile and non-fertile days of a woman's cycle, a variation of the method was already partially integrated in the FP method mix in Guatemala. When results of an SDM efficacy study<sup>7</sup> demonstrated greater effectiveness with a slightly lengthened fertility window, both the MOH and IGSS revised their FP norms and guidelines to include SDM, using the updated formula. IRH worked with the MOH, local NGOs, Faith-based Organizations (FBOs) such as Catholic Relief Services (CRS), and cooperating agencies (CAs) including University Research Corporation (URC)\*, to integrate SDM into public and private sector FP programs. In the pilot phase, IRH and partners undertook research and integration activities in six departments

### **PILOT PHASE ACHIEVEMENTS**

- Over 200 trainers and 2,000 providers able to offer SDM counseling and/or training
- SDM incorporated into national FP norms and guidelines
- SDM integrated into several public and private programs in five departments
- SDM included in the training curricula of MOH nursing programs
- Preparations initiated for SDM inclusion in health management information systems (HMIS)
- Strategies for SDM provision tested
- Cost-effective distance learning module developed and tested
- Knowledge Improvement Tool (KIT) found to be an effective supervision tool

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\* URC managed the Calidad en Salud Project (1999-2004), funded by USAID to expand the availability of FP services and improve child health at the community and primary care levels. URC was then awarded a follow-on project (2005-2009) by the same name to improve quality of and broaden access to clinical and health services, particularly for underserved populations in highland regions.

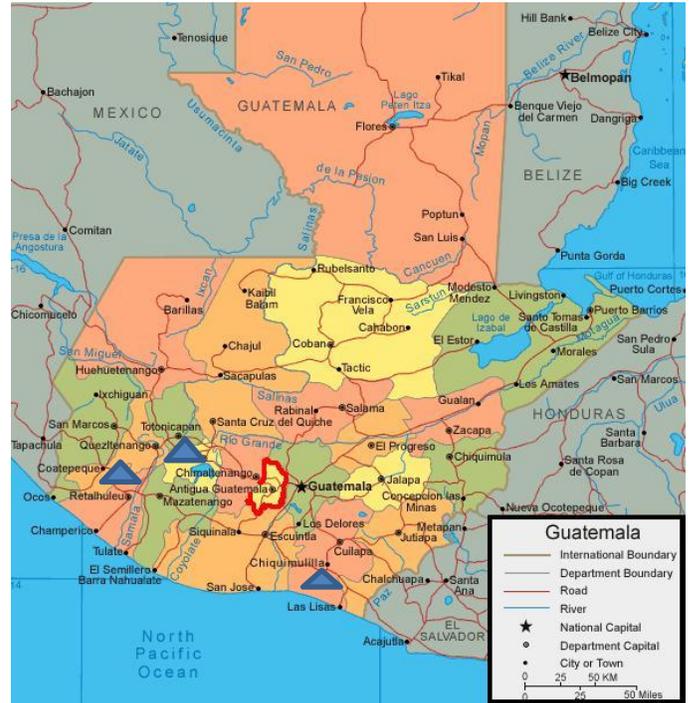
prioritized by the Guatemala USAID mission: Quetzaltenango, Solola, Huehuetenango, Santa Rosa, Chimaltenango, and San Marcos.

Guatemala served as a key country for SDM-related studies and IRH’s goal in the pilot phase was to build an evidence base for SDM that could guide the method’s introduction not only in Guatemala but worldwide. As it became apparent there was significant interest in Guatemala for SDM, focus shifted to laying the groundwork for scaling up SDM. IRH began preparations for scale-up by using research to generate evidence to support the method’s integration into programs; developing tools to facilitate adoption by programs; providing TA for building the capacity of providers, and creating information, education and communication (IEC) materials to ensure demand, availability, and high-quality services.

IRH set several objectives for its pilot phase in Guatemala, noted below with information on achievements:

- *Pilot SDM integration into public and private sector FP programs.* With SDM included in national norms, IRH worked with the MOH, NGOs and FBOs to build capacity for SDM counseling, raise awareness of the method, and strengthen service provision through research. IRH and USAID partners developed SDM training and IEC materials; NGOs then conducted SDM training for the MOH, IGSS and still other NGOs that provide FP services. Two thousand providers were trained on SDM and preparations for SDM inclusion into the HMIS took place during this time.
- *Develop and test various strategies for SDM provision.* At the MOH’s request, and based on its concern that CycleBeads’ cost would discourage potential users, IRH developed a paper image of CycleBeads. Use of the paper image was compared to use of actual CycleBeads with 600 SDM users and 90 providers over 18 months. Users and providers preferred the real beads, though users performed equally well with the paper version.
- *Develop and test a cost-effective strategy for training using a distance learning module.* IRH created a distance learning module with two formats (online and self-study), tested it with 120 auxiliary nurses, and found that both formats were acceptable and effective.
- *Evaluate cost-effectiveness of the Knowledge Improvement Tool (KIT) as a supervision tool.* The KIT, a competency checklist that includes a list of key messages and criteria for offering SDM, was previously used as a quality improvement tool in facility-based research studies. In Guatemala, IRH began to use KIT for supervision and found that it was most cost-effective when used in a group setting (rather than one-on-one) to reinforce provider knowledge of SDM.
- *Pilot SDM integration into nurse and auxiliary nurse pre-service curricula.* IRH worked with four nursing programs and succeeded in introducing SDM into their training curricula.

**Figure 1. Map of Guatemala indicating three focus departments**



## Scale-Up Phase, 2007-2012

IRH launched the SDM scale-up phase in late 2007 after receiving core funds from USAID under the FAM Project. The original strategy stated SDM was to be scaled up through facility- and community-based services in the public and private sector in collaboration with the MOH, IGSS, URC and NGOs, including APROFAM, in a phased manner, beginning in three departments (Santa Rosa, Quetzaltenango, and Sololá) and adding two departments per year until eight of the 22 departments in Guatemala were covered. This goal was subsequently scaled back, due to resource constraints coupled with coordination delays with government entities. Scale-up, instead, focused on the original three health departments which were also USAID priority areas for health interventions at that time. The goal of the five year scale-up phase was to demonstrate whether SDM could be offered at scale in the three selected departments.<sup>†</sup>

Stakeholders from the public, private and donor sectors joined IRH in late 2007 to develop a Guatemala-specific scale-up strategy over the course of several meetings. During the first meeting, participants discussed necessary components of a scale up strategy, including advocacy, social marketing<sup>‡</sup>, logistics and procurement, capacity building, research and monitoring and evaluation (M&E), and awareness-raising and demand creation. Since 2007 was also an election year in Guatemala, IRH and URC waited until 2008, when new MOH officials had taken office, to officially present the scale-up concept and negotiate sites.

A second strategic planning meeting was held in 2009, co-facilitated by IRH and World Health Organization (WHO)/ExpandNet colleagues. The WHO/ExpandNet Framework for Scale-up, which presents a systems approach to scale up reproductive health innovations, had been selected by IRH to guide its scale-up efforts in all focus countries (See Figure X). During the meeting the framework was introduced to stakeholders to guide the definition of the SDM innovation ‘package’, and to revise the earlier 2007 scale-up strategy, resulting in a

### SDM INNOVATION VALUES AND ATTRIBUTES IN GUATEMALA:

A modern, natural FP method that:

- attracts potential new users,
- facilitates understanding of the menstrual cycle which may lead to knowledge of fertility,
- helps women make decisions to take control of their bodies, and
- facilitates positive male involvement.

*“[At first] it was confusing to me. It seemed complicated...It’s hard to understand when you look at [the ExpandNet model graphic], but the more you get involved in it the more you begin to understand it, because the environment, a [resource] team, advocacy, logistics, the implementation of the whole process is important. You have to get more involved to understand how it works.”*

-- MOH/PNSR Member

*“At the beginning we were wondering whether [the ExpandNet model] had a positive purpose or what its scope would be, but as we got further into the process, I was won over by the model. I believe it is the best way to work with the population.”*

-- MOH/Health Area Member

referred to as the Resource Team). (See section on Resource Organizations.)

<sup>†</sup> The FAM Project was later extended by one year by USAID, for a total of six years.

<sup>‡</sup> The social marketing component of the scale-up strategy was later stalled due to inability to identify a social marketing organization willing to incorporate SDM into their product line and promotional services. In the final year of SDM scale-up APROFAM took on this role, with financial support from IRH.

Partners bought into using this systematic plan for SDM scale up. More than two years later, during endline stakeholder interviews, partners shared their initial impressions of the scale-up model:

Soon afterwards IRH opened an office in Guatemala’s capital, Guatemala City, and built a team which included a Country Representative and one expert each in IEC/Communications; Training; Research/M&E; and Finance/Administration, to support SDM scale-up.

**Using Data to Guide Scale-Up**

IRH and partners obtained information from various sources to measure the scale-up process and monitor use, coverage, sustainability, quality, and whether the values inherent in SDM (see box above) remained when SDM was offered at scale. M&E methods included both qualitative and quantitative approaches and tools. Table 1 shows key data sources IRH used during scale up and how they relate to primary scale-up domains.

**Table 1. Tools used to track various aspects of scale-up**

Tools/Approaches used	Coverage	Sustainability	Process	Quality	Values
Household Survey					
SDP Survey					
Provider Interviews					
Benchmark Reporting					
Service Statistics (and stock-out reports)					
Key Events Timeline					
Knowledge Improvement Tool (KIT)					
Stakeholders Interviews					
Most Significant Change					

**Primary Data Collection and Analysis**

Baseline and endline assessments of SDM scale-up took place in 2010 and 2012 and were conducted by Save the Children/Guatemala. The assessments included: household surveys, service delivery point (SDP) assessments, provider interviews, and key informant interviews with FP stakeholders. A randomly selected sample of facilities and women and men residing in selected facility catchment areas was representative of the three scale-up departments and consisted of interviews with health providers (clinic personnel and community health workers from the MOH and NGOs) and with women (ages 15 to 49) and men (ages 15 to 59) in rural and urban areas. FP stakeholders were purposively selected for in-depth interviews.

- **Household survey:** Data were gathered using the sampling frame from the National Statistics Institute of Guatemala and a pre-coded questionnaire that included questions previously tested in the National Survey of Maternal Child Health (ENSMI) and in similar studies from other countries, adapted for Guatemala. The survey was designed to measure: a) access and coverage of FP services, and b) FP-related knowledge, attitudes, and FP use. The survey emphasized SDM access, availability, knowledge, attitudes, and use. Households were randomly selected from a list of households in the three departments. In each selected household, all married women of reproductive age, and all men married to women of reproductive age, were invited to participate until the desired sample size was reached.
- **Service delivery point assessments and provider interviews:** The SDP assessment evaluated the status of SDM integration and service quality. It included three elements:
  - **Facility assessment:** A short interview with facility managers to gauge whether SDM services are offered and verify that SDM is included in record keeping and information systems, observation of the presence of SDM-related commodities and IEC materials,
  - **Provider interviews:** Interviews with clinic personnel to assess correct understanding of SDM, competency and experience in offering SDM, and attitudes (including biases) toward SDM in relation to other FP methods, and,
  - **Community health worker (CHW) interviews:** Similar to provider interviews but adapted for this type of provider.
- **In-depth interviews with FP stakeholders:** Interviews were also conducted at baseline and endline to better understand the status of and attitudes towards SDM integration and awareness, learn about the environmental factors influencing SDM scale up, and gather recommendations for improved integration and scale up. A range of organizations working in FP were selected, including groups that offered services, established national guidelines, and helped ensure women's reproductive rights. Stakeholders included MOH representatives, NGO directors and program managers, community leaders, and members of USAID bilateral and donor organizations.

Additionally, in 2010 IRH and partners used **Most Significant Change** (MSC), a participatory evaluation methodology, to learn how those involved in scale-up value SDM and capture unintended effects of the scale-up process. Stories of significant change in people's lives were collected from three groups: SDM users, providers offering SDM and program managers integrating SDM into services. APROFAM and the Quetzaltenango Health Area participated in MSC story collection and selection of the top stories of significance. The Resource Team served as the final selection committee in the process, deciding which stories expressed the most significant personal and institutional (for program managers) changes.

## Routine Monitoring and Evaluation

Data for routine M&E came from a variety of sources, including the MOH, APROFAM, IRH, and other partners.

Monitoring data were centralized in the form of a **benchmarking table**. At the beginning of the five-country scale up phase, IRH developed a set of core indicators and scale-up goals for each country. IRH staff in Guatemala contextualized these indicators and goals, defined targets for five years of scale-up efforts, and created a benchmarking table to track and evaluate annual progress toward targets, including indicators of horizontal scale up (e.g. number of providers trained, number of facilities offering SDM) and of vertical scale up (e.g. number of normative documents that included SDM, extent that SDM was integrated

into the health management information system). IRH collected benchmark data twice a year and updated the table annually.

IRH also recorded key events that could influence scale up. An **events timeline**, updated twice annually, graphically displayed key events and dates in Guatemala that might influence the scale-up process. The timeline included internal project events and external events, such as changes in MOH leadership and policy.

IRH and partners also took steps to address quality assurance during scale-up. In order to assess the quality of SDM counseling by trained providers, IRH and partners applied the **Knowledge Improvement Tool or KIT** during field supervision visits. To apply the KIT, one observes the provider delivering a simulated counseling session on SDM. When results are compiled across sites, the KIT allows supervisors to know areas of weakness in SDM counseling that can be addressed in training and one-one supportive supervision.

Routine monitoring and evaluation data were reviewed regularly by the Guatemala country team at headquarters and in the field. Data informed activities and collaboration with partners on scale-up.

## Analysis of Scale-Up as a Function of ExpandNet Elements

### Effect of The Environment on Scale-Up

The scale-up environment offered a mix of supporting and inhibiting factors. The government of Guatemala has supported FP programming for over three decades, and the overall contraceptive prevalence rate, for all methods, among women of reproductive age is currently 54 percent. However, there are a variety of factors, including politics, religion, the institutional environment, and socio-cultural diversity, which influence greater access to and use of FP, and SDM, in the country.

### Policy and Political Environment

As a whole, the political environment in Guatemala during scale-up was stable and even somewhat favorable to SDM and FP programs. In October 2009, the Guatemalan legislature approved regulations that would operationalize the *Law on Universal and Equal Access to FP Services*.<sup>§</sup> The law established a 25 percent tax on alcoholic beverages to fund SRH programs and authorized the National Commission on Contraceptive Security (CNAA) to advocate for and enforce the law with the MOH, APROFAM and private sector organizations offering FP. This was a significant step on a long road, and a key factor in the MOH's choice to integrate SDM into its contraceptive procurement plans. However, stakeholders interviewed during the baseline assessment remarked that much remained to be done to make the law a reality.

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<sup>§</sup> The *Law on Universal and Equal Access to FP Services* aims to ensure that all persons receive access to FP services, defined as information, counseling, SRH education and the provision of FP methods. The law establishes mechanisms for funding FP services at the national level in order to reduce Guatemala's dependency on foreign donors. The law is intended primarily to benefit rural populations who do not have access to basic health care services.

*"The reality for Guatemala is that men and women do not have access to all the methods that are scientifically proven [to be effective]... As a result, all the methods that one would like are not available."*

–SRH association member

*"There are limitations due to cost. Some methods are too expensive and the budget doesn't allow for them to be available for the public sector."*

– Donor representative

*"...Since the need of the country is so great, most services are curative and the preventative services [like FP] are low priority. Many FP resources are used to address the population's other needs."*

– Bilateral organization representative

IRH also noticed that the policy was not being implemented as planned and decided to get more involved in the contraceptive security process by becoming a member of the CNAA, concurrently reinforcing SDM's position in the national method mix and the inclusion of CycleBeads in MOH contraceptive procurement plans.

Religious groups, especially the Catholic Church, also exerted a strong influence on the political environment in Guatemala. This influence could have potentially provided an opportunity for SDM scale-up through Church health and social service networks. However, the Church opposed enactment of the *Law on Universal and Equal Access to FP Services* altogether, arguing that FP is a form of abortion. This had negative consequences for SDM scale-up: efforts to integrate SDM into Christian FBO health and social services and programs were met with opposition. FBOs such as Caritas who received training in SDM were unable to continue to offer SDM due to lack of support from the Church. World Vision also expressed interest in integrating SDM into its health programs, including training, promotion and service delivery, but was unable to without approval from higher levels of the organization. Although IRH is part of Georgetown University, a Jesuit school, and has worked with SDM for over 25 years, Christian churches have not yet endorsed SDM and consequently, IRH was not able to further this potential avenue to extend SDM services in collaboration with religious groups. Stakeholders interviewed at baseline confirmed the force of religious politics.

*"Religious barriers [exist], not only from the Catholic Church but also the Evangelical [Church]. It can be explained by simply saying that the church considers family planning a type of abortion."*

– Guatemalan NGO

*"In the political realm, there is a double standard. Politicians say that [contraceptive] methods are a form of abortion, but they and their families use them. They are thinking about religion, but for others."*

–SRH association

## Institutional Environment

On the institutional front, IRH signed agreements, at the request of MOH's National Reproductive Health Program (PNSR), with each of the three departments' Health Areas, specifying commitments to ensure systematic interventions to facilitate SDM scale up. This was helpful but other forces came into play in the institutional environment, such as turnover in leadership. MOH leadership changed several times during the scale-up phase, causing delays in program activities. This was successfully dealt with through persistent advocacy efforts with each new administration, including lobbying within the CNAA and advocating through the Resource Team. Additionally, SDM scale-up was sometimes influenced by the 'freeze effect' of potential administration changes. In the months leading up to the 2011 general elections, some scale up activities were put on hold until approvals from the incoming MOH leadership was obtained.

At the department and lower levels, leadership changes were minor, although health providers transferred frequently.

APROFAM, the country's largest private health services provider, also experienced leadership changes. APROFAM had four executive directors during the scale up period. As with the MOH, changes in leadership meant additional advocacy with new leaders. Furthermore, APROFAM, as a private entity that depends on fees for services and sales, was hesitant to fully integrate SDM into its program early on because awareness and use (demand) were still low. (APROFAM's position changed in late 2012. See section on Logistics and Procurement.)

The IGSS, which includes members of federal and private companies, whose income contributions maintain the institute and its private sector health services, experienced a different type of change. Prior to scale-up IGSS had a FP unit; however, when scale-up began in 2008 IGSS folded its FP unit into its MCH unit, which diluted FP services. It should be noted that while IGSS provides limited FP services, it still has FP norms, guidelines and logistics and procurement systems in place for the future. IGSS intends to resume full FP provision in the near future. During the SDM scale-up period IGSS referred FP users to the MOH.

## **Socio-Cultural Environment**

During the pilot and scale-up phase, there was a great deal of public dialogue about human rights due to the country's past civil conflict which saw many violations of human rights, especially those of indigenous people. Dialogue on human rights called attention not only to the importance of protecting indigenous rights but other human rights, including SRH. As a result, SDM was able to be positioned as a rights-oriented method that not only empowered women and couples with information on women's fertility, but also increased FP choices, providing a natural option for those who distrust hormonal contraceptives. Furthermore, SDM scale-up focused on expansion through community-level services in rural areas, where access to FP services and information for indigenous populations was limited.

## **Resource and User Organizations**

### **Resource Organizations**

Resource organizations are those capable of scaling up an innovation and providing technical assistance to others; while user organizations are those that implement an innovation. User organizations usually gain capacity over time and become resource organizations for scale up and further expansion of an innovation. As mentioned previously, the scale-up strategy-setting meetings resulted in the formation of the Resource Team. The Resource Team mandate was to serve as a forum for FP organizations to coordinate relevant FP activities and share resources, ensuring integration of new or under-utilized methods into FP services and programs.

At its creation, the Resource Team was a combination of resource and user organizations that would work to ensure SDM integration in their programs, co-led by IRH and the MOH's PNSR (see Table 2). These institutions incorporated SDM into their activities and supported its integration through advocacy within their organizations and through their networks. The Resource Team focused on:

**Table 2. Original FP Resource Team**

- Ensuring collaboration between public and private organizations during the SDM integration process
- Building the capacity of user organizations by establishing a cadre of SDM trainers
- Ensuring SDM integration into the Health Management Information System (HMIS) and that users are recorded properly.

As scale-up progressed and new opportunities arose, the Resource Team also focused on:

- Supporting community-based (non-clinical) FP service provision, including SDM provision
- Supporting development and implementation of a robust IEC component for raising awareness of SDM.

- 
1. **APROFAM**
  2. **CRS**
  3. **FESIRGUA**
  4. **IGSS**
  5. **Save the Children**
  6. **UNFPA**
  7. **MOH/PEC**
  8. **MOH/Vice Ministry of Hospitals**
  9. **MOH/PROEDUSA**
  10. **MOH/PNSR**
  11. **MOH/SIAS**
  12. **IRH**
- 

Over time, the Resource Team grew to be seen as an inter-institutional group coordinating interventions designed to bring FP to the community in a systematic manner, in part by working directly with the three Health Areas on SDM scale-up.

The MOH provided the Resource Team ‘backbone’ and systematically participated in scale up, especially the PNSR, the Integral Health Care System (SIAS) and the Extension Program (PEC). The MOH Supervision, Monitoring, and Evaluation Unit (USME) also joined the team in the final years of scale-up. Other MOH units could not prioritize FP due to insufficient staff and competing priorities. Still, representatives of the MOH Health Promotion and Education Program (PROEDUSA), the Vice Ministry of Hospitals, and USME made contributions to the Resource Team thinking and efforts.

During the final years of scale-up, two new USAID projects were awarded; NutriSalud was awarded to URC to focus on nutrition and PlanFam to Population Services International (PSI) to focus on FP. Both organizations joined the Resource Team. Other institutions such as APROFAM, CRS, IGSS, the Reproductive & Child Health Federation of Guatemala (FESIRGUA), UNFPA, and Save the Children were involved in the Resource Team less systematically. Some had no permanent representative on the team because they lacked the required support from their organization. Others sent ad hoc representatives to meetings, which made organizational continuity difficult.

The Resource Team met on a monthly basis to review and update their work plan in coordination with Health Areas. Some members participated in M&E visits to health centers to monitor FP services and commodities with financial support from IRH. Members of the Resource Team also participated in the evaluation of SDM using the MSC evaluation methodology.

Overall, the Resource Team’s existence had a positive impact. Its achievements included coordination between member organizations and several critical scale-up ‘wins’, such as inclusion of CycleBeads in the MOH procurement list and development of a training strategy for FP service provision at the community level through TBAs. However, the Resource Team faced a number of challenges, including inadequate resources, lack of interest from some key organizations in supporting SDM scale-up, competition among team members, and high turnover of FP technical advisors at the PNSR. These challenges limited the Team’s effectiveness in fulfilling its mandate.

## User Organizations

A user organization is one that implements an innovation, including FP services. In IRH's analysis, several incentives favored ongoing integration or sustainability of SDM in the FP method mix by user organizations. First, the MOH embedded the method in several key protocols which mandated that the method be offered. Second, Guatemala hosts several watchdog organizations that monitor the availability and quality of health services, and advocate for a full range of FP methods according to MOH policy and national law.

The largest user organizations, the MOH and APROFAM, evolved into resource organizations. By the end of the scale-up phase, the MOH and APROFAM had the greatest capacity and likelihood to sustain SDM services in the future. The MOH will continue to offer SDM because its policies mandate it to do so. APROFAM may find most of its motivation to continue to offer SDM based on future demand for the method and generating revenue from sales of CycleBeads in their clinics.

Other user organizations include an array of smaller NGOs that were members of the MOH PEC. More than a dozen PEC organizations received training and technical assistance to offer SDM. These NGOs receive contraceptives from the MOH and small amounts of funds for service delivery. Their ability to offer SDM will be influenced by MOH funding and operations (e.g., whether or not they receive funds in a timely manner). Because throughout the scale-up phase they received CycleBeads directly from IRH, their future supply will have to come from another source.

Still other user organizations included FBOs interested in offering natural FP and some international NGOs, such as ChildFund, which incorporated SDM into their community-level FP promotional activities.

## Continued Analysis of ExpandNet Elements: Strategic Choice Areas

Throughout the course of scale-up, IRH acquired a firm understanding of the environment, resource possibilities, and partners and their scale-up capacity and interests. IRH made strategic choices about training and service delivery strategies, IEC messaging, advocacy, and how to position SDM within the larger FP context to maximize the method's integration into existing systems and secure its longer-term sustainability.

## Building Service Provider Capacity

### Health Facility-Level Training

At the start of the scale-up phase, IRH hired a Training Officer to lead technical assistance efforts to build the capacity of health providers. These activities include facilitating FP training, including SDM, or providing refresher training for providers previously trained on SDM. In most cases, IRH trained master FP trainers at the MOH and NGOs who then trained providers. Job aides and a training manual were developed to support training activities. IRH and partners were able to surpass their benchmark for number of individuals trained to offer SDM and leave behind a cadre of SDM trainers. (See Benchmarking Table in section on Scale-up Results.)

The KIT was used at training events throughout the scale-up process to monitor competency and quality of SDM training among nurses, auxiliary nurses and TBAs. Below is a summary of KIT results (Table 3) from

provider training on SDM mid-way through the scale-up period, which indicates a high level of provider competency to offer SDM.

**Table 3. SDM KIT Results with Professional Nurses and Auxiliary Nurses, 2010-2011**

	Quetzaltenango N=66	Santa Rosa N=24	Sololá N= 16
<b>ELIGIBILITY CRITERIA FOR THE STANDARD DAYS METHOD</b>			
Women who have their period every month or when it is expected.	87%	95%	100%
Couples who are able to use condoms or abstinence when the woman is able to become pregnant (white bead days).	71%	73%	56%
<b>HOW CYCLEBEADS WORK</b>			
The <b>RED</b> bead represents the first day of the woman's period (menstrual cycle).	96%	96%	100%
The <b>BROWN</b> beads represent the days when there is less likelihood of pregnancy.	96%	92%	100%
The <b>WHITE</b> beads represent the days when the woman can become pregnant.	94%	96%	100%
<b>HEALTHY TIMING AND SPACING OF BIRTHS</b>			
Wait at least two years after childbirth before trying to become pregnant again.	94%	97%	100%

\*Results compiled from SDM KIT reports.

## Community-Level Training

**Training Traditional Birth Attendants** - A large proportion of rural, indigenous Guatemalans do not live near even a third-tier health post, and have no access to clinic-based FP services. Using standards set forth in the MOH's national FP Guidelines, IRH provided technical assistance to PNSR in the design, implementation and evaluation of a strategy that authorized TBAs to provide select contraceptives and counseling at the community level, extending access to SDM in the process. The training intervention aimed to enable TBAs to promote all FP methods; offer four methods: oral contraceptives, condoms, Standard Days Method (SDM) and Lactational Amenorrhea Method (LAM); and refer for other methods. The strategy included four components:

- 1) Training TBAs to promote and provide FP methods;
- 2) Connecting TBAs with auxiliary nurses who train and supervise them;
- 3) Supplying TBAs with commodities; and
- 4) Linking TBAs to the reporting system of the MOH's central HMIS.



**Figure X. The TBA FP Manual (left) and TBA Facilitator's Guide (right).**

This initiative was tested at small scale in Quetzaltenango (53 TBAs and 15 facilitators) and Santa Rosa (32 TBAs, seven facilitators). To evaluate effectiveness of the training, IRH used a four-method KIT to assess competency on eligibility criteria and key messages for all four methods, as well as messages on Healthy Timing and Spacing of Pregnancies. Table 4, below, provides KIT results on knowledge of the four methods

TBAs offered.\*\* While their level of competency is not as high as clinical providers, above, TBAs do demonstrate potential to offer FP with on-going support and refresher training.

**Table 4. TBA Knowledge of essential information for each method, 2012 (TBA KIT reports)**

Method	% of TBAs N=29
LAM	62%
SDM	79%
Condoms	72%
Oral contraceptives	59%

Using service statistics from the intervention area and a control area, results showed a slight (intervention vs. control)-to-moderate (intervention vs. pre-intervention) increase in FP users. Program managers and TBAs found the service extension strategy acceptable as it makes FP more accessible in rural communities. Program managers also mentioned factors that could limit the strategy’s feasibility, including resistance from local health centers due to increased workload (e.g. more time needed by auxiliary nurses to work with TBAs, merge information from TBA reporting forms with clinic reports). Overall the strategy has the potential to help increase demand for FP methods and help expand access at the community level.

### Pre-Service Education

In the pilot phase, SDM had been integrated into the curricula of four nursing schools in Quetzaltenango and Santa Rosa. During the scale-up phase, refresher trainings were provided to these schools to strengthen the capacity of nurses, auxiliary nurses and rural health technicians to offer SDM counseling. To assess the state of SDM integration in nursing programs, strengthen how SDM is taught, and improve the likelihood that an SDM module remain in the curricula, IRH conducted a series of interviews during the scale-up phase, with directors, instructors, and coordinators at seven nursing programs. Twenty individuals from four national and three regional schools were interviewed.

Interviewees considered SDM to be well integrated into their nursing curriculum. The method continued to be taught as a standard component of the FP training. Interviews revealed most schools increased the amount of time devoted to SDM in order to teach the method ‘in sufficient detail’. Time allocated for SDM instruction ranged from 30 minutes to three hours, as compared to 30 minutes to two hours for injectables and 30 minutes to one hour for oral contraceptives.

*SDM takes us more time to teach because as it is a natural method, there are many things that students don’t know and that they should know about the female body. As they learn, they express doubts about the method, which need to be resolved in class ... If they don’t know what a menstrual cycle is and what a period is, we begin with that. Additionally, they have to be able to counsel people on the method in a way that interests them....*

*– Instructor, Nursing Program*

According to interviewees, students obtain a solid understanding of SDM and can later provide adequate counseling. However, some SDM messages that needed strengthening during instruction were identified:

- the difference between the menstrual cycle and menstruation,

\*\* A new version of the KIT was developed for this intervention. The KIT includes questions on eligibility criteria and key messages for SDM, LAM, pills and condoms.

- that SDM is only appropriate for women whose cycles are between 26 and 32 days long, and
- the meaning of the dark brown bead on CycleBeads.

All of the interviewees expressed a commitment to continue providing instruction on SDM in their programs. Interviewees spoke of the importance of SDM in the context of rights and responsibilities, balanced counseling, and informed choice.

As a follow-up to these interviews, in 2012 IRH and the MOH's Training Department co-facilitated a training workshop in Guatemala City for 17 faculty members from 10 national and regional nursing schools, including these and schools in other departments. The workshop served as an initial training for some programs and as a refresher training for others.

### Continuing Education

While IRH provided technical assistance to partners for training of trainers and cascade trainings, it was evident that distance learning options would be beneficial in providing a low-cost, accessible training approach for providers.

**SDM Self Study Course** - IRH developed an SDM Self Study Course, which was validated in Guatemala and other countries. The course includes a review of the training manual followed by an in-person examination to demonstrate mastery of the material. The participants can retake the exam if they do not achieve a passing score the first time.

To assess the feasibility of offering this course within the MOH/DECAP's continuing education courses, the DECAP initially offered the course to a small group of nurses based in Guatemala City. Forty-six nurses registered for the course in 2010 and 31 took the examination. Of these, 16 achieved a score of 85% or higher and received a diploma indicating they are competent to offer SDM. According to examination results, participants found the following topics most difficult:

- the meaning of the dark brown bead of CycleBeads
- what to recommend to women with using CycleBeads with short cycles, and
- counseling women who wanted to switch to SDM from oral contraceptives.

Overall results indicated that nurses could achieve a high level of competency in SDM through the self-study. However, self-study may not be appropriate for all providers, and alternate training options are recommended for those who do not pass the examination after two attempts. Based on these results, DECAP planned to offer the course to nurses and auxiliary nurses in the departments of Chimula, El Progreso, Izabal, Zacapa, and Jutiapa. Though these were not scale-up departments, the expansion of the course to other departments represents an important step towards the integration of SDM throughout the country.

**SDM Online Course** - To make SDM training readily accessible to health care professionals and other interested parties, IRH prepared an online SDM training course for Guatemala. The course was developed by IRH in English and then translated into Spanish for use in Latin America. Participants would study course material and at the end of the course, they would take an online exam to assess their competency in the method.

Between June 2011 and October 2012, 151 people completed the SDM online course. Most course participants were in the medical profession; doctors, nurses, auxiliary nurses, rural health technicians

comprised the majority of the participants. Nearly all course participants resided in Guatemala City, Quetzaltenango, or Sololá. Most participants that completed the course, passed with a satisfactory score on their first attempt.

## Advocacy

To gain and maintain political and technical support of key stakeholders, IRH and partners participated in relevant meetings and networks to promote SDM scale-up activities and disseminate scale-up results. Scientific articles and briefs produced by IRH supported advocacy efforts. Advocacy generated opportunities for partners to engage in the scale-up process, which in turn, encouraged partners to become more involved and eventually take ownership of scale-up. Another factor that facilitated scale-up was that SDM was consistently presented as one of a range of methods. Many partners, including USAID bilaterals, were initially hesitant to participate in SDM scale-up because they felt that providing special attention to one method was unethical or outside of their organization's scope of work.

One example of successful advocacy for SDM's inclusion in materials is IRH's negotiations with PAHO, UNFPA and the MOH to include SDM in the World Health Organization FP medical eligibility criteria wheel for Guatemala. The wheel is a simple tool for providers to use to assess clients' eligibility to use certain FP methods. Development of the wheel for Guatemala was initiated by IRH after it was produced for another project in Bolivia. Advocacy with PAHO, UNFPA and the MOH was successful; PASMO, a local affiliate of PSI, printed the tool for local distribution within the MOH.

The Resource Team also played a critical role in advocacy at different points in scale-up. The Resource Team successfully advocated for including CycleBeads in the MOH procurement list and FP budget and piloted the strategy to offer FP at the community level through TBAs. Eventually, the PNSR advocated to make the Resource Team's existence official within the MOH system, and contributed resources for pilot interventions and monitoring activities conducted by the team.

Champions were another element of advocacy. Members of the MOH and APROFAM were key players in SDM advocacy efforts throughout the scale-up process. The strongest advocates came from the MOH's PNSR and other units of the MOH.

Finally, as a way to facilitate access to materials and resources developed during scale-up on SDM integration, IRH developed the SDM Integration Toolkit. The toolkit, a Spanish-language website housed by K4Health.org, includes a copy of all Guatemala-specific SDM materials, such as the TBA manual, SDM advocacy briefs and distance learning courses. The toolkit's link was disseminated among the MOH and APROFAM, who will continue to use its resources.

### **Positioning SDM innovation within the context of human rights**

SDM scale-up was supported by the fact that the country was experiencing a time of reflection on human rights, including sexual and reproductive rights, after the end of the civil war.

The government created a department under the MOH for the protection of indigenous rights to information and access to health services, the Unidad de Pueblo Indigenas (UPI) or the Indigenous Communities Unit. The MOH also created a mechanism for addressing gender in government systems while various women's rights and watchdog organizations were established in the country.

IRH understood the importance of taking into account indigenous rights when scaling-up SDM. The UPI was invited and later joined the Resource Team. As IRH developed IEC materials images of indigenous women and families were explicitly included alongside Ladino images, so that materials would resonate with indigenous populations.

IRH also decided to directly address gender and human rights in training activities. SDM was positioned as a method that empowered women (and providers) with SRH knowledge about the menstrual cycle and fertility.

## Demand Creation

Raising awareness and creating demand for SDM was an integral part of the scale-up strategy. While the pilot phase had introduced the MOH and FP organizations to SDM, the general public was mostly unaware of the method's existence. Results from the baseline assessment showed that women's awareness of SDM was 24 percent, while men's was 27 percent. In order to raise awareness, increase knowledge and create demand for SDM, IRH partnered with local and international NGOs, as well as a telecommunication company for the dissemination of FP and SDM messages. During the baseline assessment women and men were asked what mediums they preferred for receiving FP messages. Table 5 shows the top three mediums mentioned by men and women, with radio being listed as the top choice for both.

**Table 5. Preferred mediums for FP messages**

	Women N=499	Men N=206
Radio	46%	37%
Television	18%	14%
Interpersonal communication	3%	
Newspaper/magazine		3%

## Mass Media

**Radio Campaigns:** Due to the fact that radio was mentioned as the preferred medium for receiving FP messages, a radio campaign was designed to use community radio to disseminate locally developed messages about SRH, FP and SDM. IRH worked with the Federation of Guatemalan Radio Schools (FGER) to develop a series of radio spots and broadcast them via community radio stations. Produced in Spanish, Kaqchikel, K'iche, and Mam, the spots were short dramas that included messages on reproductive rights, the menstrual cycle and SDM, and male involvement in FP. During the first phase in 2010, FGER chose six community radio stations in the three departments to broadcast the radio spots.

IRH then evaluated the campaign's effectiveness through a survey for listeners and interviews with radio disc jockeys. Of 101 people who had heard the radio spots in Quetzaltenango and Sololá, 94 percent spontaneously remembered hearing messages about FP and 38 percent reported that they had sought additional information about FP after listening to the spots. Seventy-one percent said they had discussed the messages with relatives, partners, or friends, indicating that the campaign had a multiplier effect. Results suggested the campaign was well received by the population as respondents reported that they identified with the stories because they were broadcast in their native language. However, the evaluation also indicated that SDM messages were some of the *least* retained.

For a second round of broadcasts aired in 2011, a new spot focused on SDM, with supporting information about the menstrual cycle and FP methods. This radio spot along with others were broadcast by the same six stations in the four languages, plus T'zutujil at the suggestion of Sololá health officials. A third round was broadcast in the five languages in 2012. According to FGER, the radio campaign reached approximately three million listeners: covering the population of all three focus departments and their surrounding areas.

The effectiveness of the radio campaign is unclear given that only 4.8% of women and 14% of men who had heard of SDM at endline mentioned radio as the source of information. Since the messages from the

campaign were broadly accepted, other organizations, including FESIRGUA, PSI, IGSS, APROFAM and the Health Areas of Quetzaltenango, Sololá and Santa Rosa, went on to rebroadcast the spots.

## Community-Based Promotion

**Training Health Promoters:** An IRH assessment found that providers responsible for health education and promotion had little specific training or materials with which to do their jobs, and missed opportunities to reach men and women with information. IRH designed a guide for training health promoters which included theoretical and practical modules, and an instructional video. Training focused on effective and engaging ways of bringing FP and SDM information to the community. Additionally, health promoters were given materials for distribution that included SDM and FP messages, including t-shirts, wash cloths, pens and tote bags.

**Motorcycle Taxi Campaign:** A campaign to distribute FP promotional materials and CycleBeads flyers via motorcycle taxis was piloted in Cuilapa, Santa Rosa, as a way to get printed materials to the general public outside of a health setting. Motorcycle taxis are a mode of transportation commonly used for short trips in Guatemala's urban and peri-urban areas. Motorcycle taxi owners and drivers were trained on the topics described in the materials and asked to refer interested passengers to health services. The goal was to encourage people who received materials to go to health services and ask for more information on SDM or FP in general.

Midway through the campaign, focus group discussions were held with motorcycle taxi owners and drivers, who reported that passengers (and especially youth) showed interest in the FP information. It was recommended that future campaigns include more FP orientation for drivers. The campaign's effectiveness was not evaluated and the endline assessment did not ask about whether men and women heard of SDM from motorcycle taxis. The strategy was later adopted and implemented by PSI's PlanFam.

**Each One Invites Three Campaign:** Each One Invites 3 (EOI3) was based on a social diffusion initiative IRH adapted from a SanteNet project in Madagascar, where satisfied FP users gave their non-user friends an 'invitation card' to visit a health center to obtain information on a FP method of their choice. The invitation card created a dialogue between friends about FP in general and the users' experience in particular. IRH collaborated with ChildFund to implement EOI3 in one district of Sololá through CHWs, and subsequently worked with the MOH to implement the strategy in Santa Rosa and Quetzaltenango through TBAs. The campaign raised awareness of all FP methods, including SDM, and increased requests for information and method uptake. In all, 69 satisfied users and health providers distributed 4,150 invitations, and 1,207 people sought additional FP information after receiving an invitation card.

**Street Banners and Loudspeaker Campaign:** IRH received approval from 57 municipalities in the three departments to hang street banners promoting SDM. Over the course of one month in 2012, the banners drew attention to SDM; some officials expressed interest in working with IRH to promote SDM and train CHWs to offer the method. A loudspeaker campaign was implemented in 26 municipalities. For two months, loudspeakers on vehicles and motorcycle taxis circulated through areas where people congregate, broadcasting messages about SDM and SRH to encourage FP uptake. According to the endline assessment, 2.4% of women mentioned loudspeakers as a source of SDM information.

**Interactive Community Activities:** A series of interactive community activities were held in public areas, including municipal plazas, to create public dialogue on FP and bolster the impact of other IEC initiatives. The activities were initiated by IRH, FGER and the MOH soon after completion of the first round of the radio campaign. Disc jockeys from community radio stations that had worked with FGER hosted the first round

of community talks, accompanied by a local MOH provider. During the one to two hour sessions hosts played radio spots, led contests and shared information and promotional materials on SDM and FP. Activities were followed by a question and answer session led by health providers to provide an opportunity for the audience to receive information about specific FP and SRH topics, as well as clarify FP myths. Participants were also encouraged to listen for radio spots in their communities. According to FGER, the interactive community activities reached nearly 10,000 people throughout its implementation. Men were active participants in many events and often approached health providers with questions.

## MHealth Promotion

**Mobile Phone Technology - Ring Back Tones:** IRH partnered with the telecommunications company TIGO to produce an SDM ring back tone, a recorded message that a caller hears while waiting for the phone to be answered. The ring back tone gave brief information about SDM and prompted listeners to “press 3 for more information.” Those who wanted more information received a text message with details on SDM and instructions to visit a health provider for more information. The ring back tones were broadcast over the course of one month in 2012. According to TIGO the messages were sent to almost 80,000 people in the three departments: 47,000 people in Quetzaltenango, over 21,000 in Santa Rosa and 11,000 in Solola.

While the endline assessment captured data on awareness of SDM, activity-specific evaluations were not usually conducted due to resource constraints. It is worth noting that overall these demand creation interventions were implemented at pilot levels, so a more pronounced level of impact in SDM awareness was not expected.

## Logistics and Procurement

A critical barrier to SDM sustainability centered on procurement of CycleBeads. As the scale-up phase began, CycleBeads had not yet been included in the logistics and procurement systems of the largest FP service organizations. The MOH procures contraceptives through UNFPA, and APROFAM procures directly from global distributors. However, CycleBeads had never been procured by either organization. Moreover, the supply chain was weak, and frequent FP commodity stock outs were the norm.

IRH addressed these barriers through short and long-term measures. During the scale-up period IRH provided 20,000 sets of CycleBeads for Guatemala, donated mostly to the MOH but also given to NGOs for service delivery and training activities. While IRH viewed donations as a temporary solution, it undertook strategic efforts to ensure that CycleBeads would continue to be available in logistics and procurement systems. IRH advocated with the PNSR, the PNSR logistics unit, and APROFAM to raise awareness about the contribution SDM could make to Guatemala’s national SRH program and the need for including CycleBeads in procurement systems. As a result of these efforts, CycleBeads were included in the MOH procurement list in 2011. Soon afterwards, the MOH informed IRH of their interest in purchasing 5,000 CycleBeads. With no local distributor in Guatemala, the MOH was advised to contact UNFPA/Guatemala requesting that they include CycleBeads in their procurement list. Unfortunately, UNFPA/Guatemala would only place orders for contraceptives currently on their contraceptive list, which at the time did not include CycleBeads. Since then (late 2011), UNFPA headquarters now includes

**Figure 2. APROFAM-designed packaging for CycleBeads related products**



CycleBeads in their FP contraceptives catalog (RH Access). It remains to be seen whether UNFPA/Guatemala will add CycleBeads to their local procurement list.

Given that efforts to convince UNFPA/Guatemala to procure Cyclebeads did not seem promising, IRH sought other avenues to ensure CycleBeads would be available. In December 2012 after much advocacy on the part of IRH, APROFAM became the CycleBeads distributor for Guatemala and engaged in promotional and training activities to ensure SDM sustainability in the private and public sectors. As the largest private sector distributor of reproductive health supplies, APROFAM is well-placed to ensure CycleBeads remain widely available and SDM continues to be promoted alongside other contraceptive options.

IRH donated 18,000 sets of CycleBeads to APROFAM which plans to use the funds from CycleBeads sales for future purchases of CycleBeads directly from Cycle Technologies, the manufacturer of CycleBeads, creating a revolving fund. As the local distributor, APROFAM will sell CycleBeads to FP service networks (including the MOH), distribute CycleBeads through its existing distribution system for contraceptive supplies, and include CycleBeads in its logistics system and social marketing programs. CycleBeads will be sold alongside other FP methods at all pharmacies in each of the organization's 28 clinics and hospitals throughout the country. Additionally, APROFAM's community distribution network and marketing department will promote and distribute CycleBeads to NGOs, health organizations, women's groups, private sector pharmacies, medical offices, and other organizations that want to offer CycleBeads.

APROFAM designed new packaging and promotional materials to brand SDM products, as seen in Figure 1. To differentiate the product for different consumers, a 'luxury' version of CycleBeads includes CycleBeads and 12 condoms, while the standard version only includes CycleBeads. APROFAM's social marketing materials include billboards, fliers and brochures for clinic waiting areas, and large laminated cards for providers. APROFAM will also re-broadcast radio spots IRH aired during its demand creation activities.

## Resource Mobilization

USAID/Guatemala funding support for SDM scale-up was limited to Years 2 and 3, when they allocated \$200,000 of field support funding to IRH. The resource constraints in the last two years of scale-up influenced the level of TA, training, and promotion activities that could be undertaken by IRH and its partners. Going forward, USAID informed IRH that funds for FP-related TA would be channeled through the two new projects, PlanFam and NutriSalud.

## Scale-up Results in Guatemala

As of December 2012:

### SERVICE EXPANSION

SDM services are available in 94-96% of service delivery points in the three scale-up departments

Fourteen organizations have the capacity to train, deliver services or lend technical assistance on SDM

### INSTITUTIONALIZATION

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

- Norms, policies, guidelines
- Pre-service and in-service training curricula
- Logistics systems
- HMIS reporting systems

### SDM USERS & KNOWLEDGE OF SDM OPTION

35% of women in the scale-up departments had heard of SDM at endline.

SDM users comprised about 2.3% of all FP users at endline.

Primary reasons for SDM discontinuation included becoming pregnant (planned or not) or wanting to become pregnant.

Estimates of leveraging by partners – estimated expenses of partner activities that support SDM expansion (e.g. costs of broadcasting radio spots, independent of IRH technical or financial support) was a monitoring objective, because leveraging is a proxy for other organizations taking ownership of scale-up. Between September 2009 and December 2012 an estimated \$170,000 was leveraged, mostly from the MOH and partners involved in demand creation activities, including radio stations and telecommunications partner TIGO.

## Scale-Up Results – The Extent to which SDM Is Integrated In 2012

Assessment of scale up integration requires understanding of complex factors. In order to assess scale-up success, we evaluated accessibility of SDM in facilities and services (horizontal scale-up), as well as integration into normative documents and FP support systems (vertical scale-up). This section discusses scale up achievements from horizontal and vertical systems perspectives through data from the events timeline, stakeholder interviews, and benchmarking table and then moving to the population perspective through assessments on awareness, attitudes, use and availability of SDM.

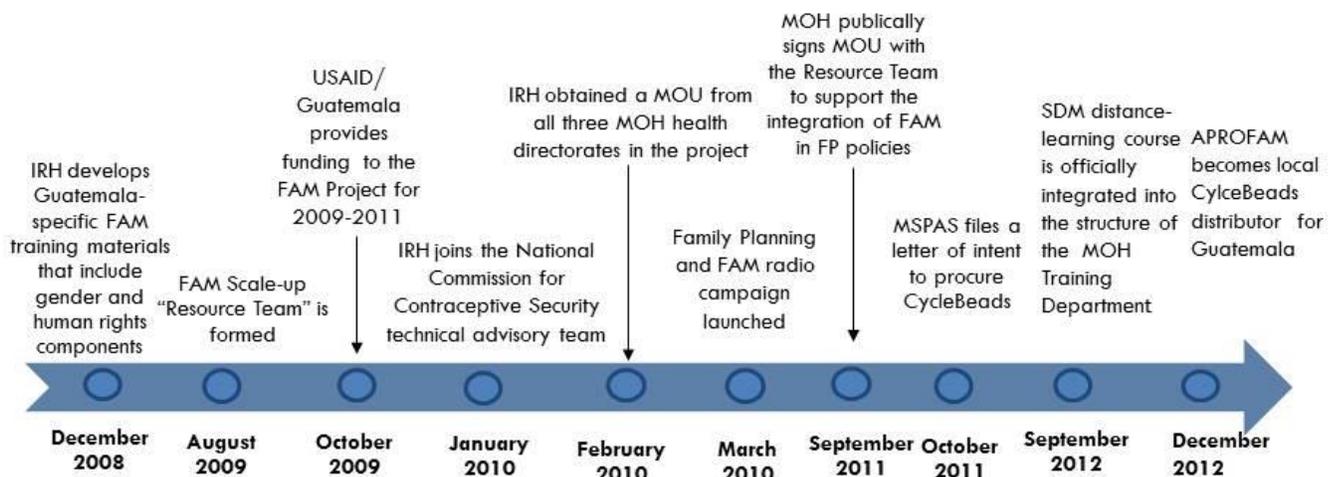
SDM scale-up was limited to three departments, with the goal of establishing evidence that scale up could be successfully achieved at the department level which would provide support and evidence to scale up SDM at the national level. Results presented here are from the three departments which comprise the geographic expansion goal of scale-up.

## Expansion and Integration

### Events Timeline

The events timeline below, a condensed version of the full timeline, highlights some of the key events that occurred in Guatemala during the scale-up period. These events will be discussed further in relation to scale-up achievement and results.

**Figure 3. Guatemala SDM Scale-up Events Timeline**



## Stakeholder Interview Results

In late 2011 endline stakeholder interviews were held with 18 representatives of government agencies, donor and cooperating agencies, and NGOs, to obtain opinions on the process and results of SDM scale-up, the degree to which SDM is institutionalized, and recommendations for future integration.

At endline stakeholders had more accurate knowledge of SDM effectiveness and more positive opinions of the method compared to baseline. IRH's efforts to disseminate information on the method's effectiveness and promote the importance of balanced counseling were cited as critical in changing negative attitudes and biases towards SDM.

Stakeholders reported that the ExpandNet framework was a useful approach to SDM scale-up, and saw its applicability to other types of programs and projects. They noted that training on SDM enriched understanding and explanation of other FP methods because it includes information on the menstrual cycle and fertility, which helps providers counsel on how other contraceptives work. Stakeholders noted several benefits of SDM integration, including that the method:

- promotes SRH rights by expanding the range of available FP methods,
- meets the needs of women seeking natural methods,
- is acceptable to women and couples whose religion does not allow them to use other methods,
- increases knowledge of the menstrual cycle and fertility for users and health personnel,
- increases use of other methods (such as condoms), and
- promotes couple communication for FP.

Stakeholders also identified some challenges in SDM scale-up, namely, turnover in MOH personnel and Resource Team members, integrating and correctly recording SDM in the HMIS; and dealing with the country's cultural norms, such as machismo. Stakeholders noted that ongoing training would be essential for SDM's continued availability. Nevertheless, about half of stakeholders considered that SDM was sufficiently institutionalized, as it is included in the country's legislation and national FP guidelines as well as in the training platforms for health personnel.

## Results from the Benchmark Table

IRH made regular use of data from public and private service providers and other sources to track progress against a set of benchmark indicators. Table 6 shows achievement of those targets.

**Table 6. Guatemala SDM Benchmarks (through December 2012)\***

<b>Guatemala End of Project Goal:</b> By 2013, SDM will be well established in three departments (one sixth of the country): Sololá, Quetzaltenango, and Santa Rosa						
<b>Total population for Quetzaltenango, Santa Rosa and Solola:</b> 1,573,093						
Horizontal scale-up	Year 1**	Year 2	Year 3	Year 4	Year 5/6	Target
Proportion of <b>service delivery points that include SDM</b> as part of the method mix	0	0	132 (43%)	213 (69%)	305 (99%)	308
Estimated number of <b>individuals trained</b> to counsel clients in SDM (IRH-supported)	236 (13%)	723 (40%)	1,215 (67%)	1,361 (75%)	1,973 (109%)	1,809

Number of <b>organizations that have capacity</b> to undertake SDM activities (are resource organizations)	0	7 (47%)	10 (67%)	12 (80%)	14 (93%)	15
<b>Vertical scale-up</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>	<b>Year 5/6</b>	<b>Target</b>
SDM included in essential or <b>key policies</b> , norms, guidelines, and protocols	0 (0%)	0 (0%)	3 (75%)	4 (100%)	4 (100%)	4
Presence of public or private training organizations that include SDM in <b>pre-service training</b> and/or continuing education	0 (0%)	0 (0%)	1 (33%)	2 (66%)	3 (100%)	3
Presence of public or private training organizations that include SDM in <b>in-service training</b>	3 (27%)	9 (82%)	10 (91%)	11 (100%)	11 (100%)	11
Sustainable inclusion of <b>CycleBeads in donor</b> procurement system	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (33%)	3
Sustainable inclusion of <b>CycleBeads in logistics</b> systems	0 (0%)	0 (0%)	0 (0%)	1 (33%)	2 (66%)	3
Inclusion of <b>SDM in MIS</b> /reporting systems	0 (0%)	0 (0%)	1 (33%)	2 (66%)	2 (66%)	3
Inclusion of <b>SDM in IEC activities</b> , materials and mass media	0 (0%)	4 (36%)	5 (45%)	9 (82%)	11 (100%)	11
Inclusion of <b>SDM in surveys</b> (e.g. DHS)	0 (0%)	0 (0%)	1 (25%)	1 (25%)	2 (50%)	4

\* Numbers and percentages are cumulative; percentages are based on end of project targets

\*\*Year one results under Horizontal Scale-up include pilot phase accomplishments

Benchmarks and achievements along the horizontal or expansion axis:

- **Proportion of SDPs that include SDM as part of the method mix**  
Three hundred and five SDPs have integrated SDM. Note that the facility assessment, which provided generalizable results of percentage of SDPs integrating SDM, provides more accurate information: between 94 and 96 percent of service delivery points offer SDM.
- **Estimated number of individuals trained to counsel clients in SDM (IRH-supported)**  
The goal of 1,809 individuals trained to counsel clients in SDM was surpassed for a total of 1,973. This figure includes facility and community-based providers, including doctors, auxiliary nurses, TBAs and other CHWs.
- **Number of organizations that have capacity to undertake SDM activities (are resource organizations)**  
IRH intended to develop capacity to undertake SDM activities in 15 organizations, and achieved 93 percent of that target. Changes in staffing and focus of the original 15 organizations played a role in failure to meet this benchmark.

Benchmarks and achievements along the vertical or integration axis:

- **SDM included in essential or key policies, norms, guidelines, and protocols**  
SDM was effectively included in four normative policies in Guatemala: the MOH's national SRH norms; IGSS' FP norms; APROFAM's clinical protocols; and MOH's FP guidelines.

- Presence of public or private training organizations that include SDM in pre-service training and/or continuing education  
SDM was successfully integrated into pre-service and continuing education platforms, including a distance learning course and an on-line course.
- Presence of public or private training organizations that include SDM in in-service training  
SDM was also integrated into the training agendas of various FP organizations whose trainers received and replicated SDM training.
- Sustainable inclusion of CycleBeads in donor procurement system  
IRH intended to include CycleBeads in three procurement systems: the MOH, UNFPA/Guatemala and APROFAM. In spite of intensive efforts, CycleBeads were ultimately included in one system – that of APROFAM. However, inclusion of SDM in APROFAM’s procurement system means that the MOH can now purchase CycleBeads from them and creates a mechanism for the MOH to purchase CycleBeads.
- Sustainable inclusion of CycleBeads in logistics systems  
IRH targeted three entities for inclusion of CycleBeads in their logistics systems: the MOH, APROFAM and IGSS. By the end of the scale-up phase, the MOH and APROFAM had incorporated CycleBeads but IGSS had not.
- Inclusion of SDM in MIS/reporting systems  
IRH targeted the MOH, APROFAM and IGSS to include SDM in their reporting systems. SDM was incorporated into the reporting systems at the MOH and APROFAM; however, it remains unclear if SDM is currently included in IGSS reporting systems.
- Inclusion of SDM in IEC activities, materials and mass media  
IRH worked with the MOH, NGOs and private organizations to both conduct IEC activities and develop materials to disseminate messages about SDM. Activities included interactive community activities and airing FP and SDM messages on radio programs and cell phone ring-back tones. Materials included SDM brochures, flyers and stickers, as well as a Guatemala-specific SDM insert.
- Inclusion of SDM in surveys  
IRH set out to include SDM in four surveys: the ENSMI, the MOH Lot Quality Assurance Sampling (LQAS) survey conducted by URC, and the baseline and endline assessments conducted by Save the Children/Guatemala on behalf of IRH. IRH was only able to have SDM included in its own assessments. However, SDM will be included in the next ENSMI, scheduled to take place in 2014.

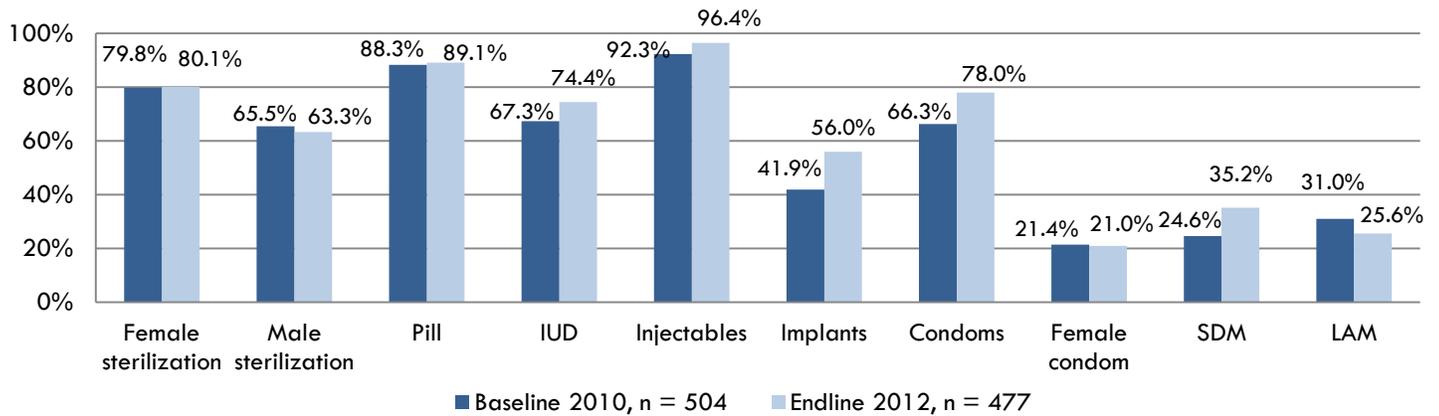
## Awareness, Attitudes, and Use

Scale-up integration needs to be assessed from a population perspective and not just a systems perspective. *How well is SDM known compared to other methods? What is the general opinion of SDM? What proportion of FP users have chosen SDM?*

Results of the household surveys and facility assessments showed important increases over the scale-up period in women’s and men’s awareness of SDM, improved attitudes towards the method, and increased use of SDM. Survey results showed that women had a greater overall awareness of FP methods at endline, as well as substantially greater awareness of SDM. Thirty-five percent of women had heard of SDM, an increase of nearly 11% over the course of the scale-up period (See Figure 1). Although awareness of SDM

increased, it was still lower than awareness of other modern FP options at endline, including implants (56%), IUD (74%), and injectables (96%).

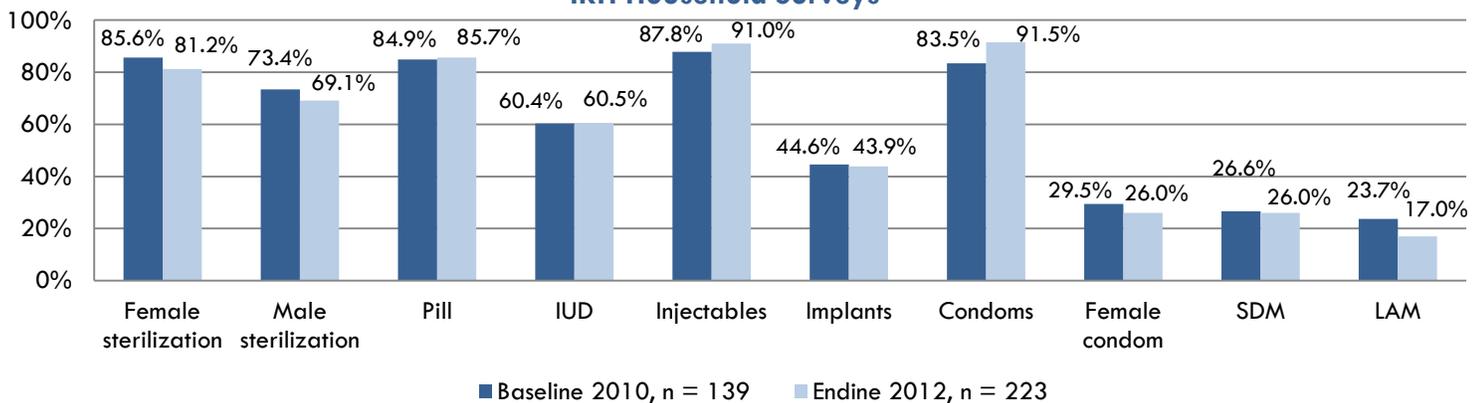
**Figure 4. Change in Awareness of FP Methods from baseline to endline among women**  
**PERCENTAGE OF WOMEN WHO KNEW OF FAMILY PLANNING METHODS**  
**IRH Household Surveys**



Men’s awareness of SDM hardly changed throughout scale-up (26.6 percent to 26 percent). This is a surprising result, given that SDM-specific awareness raising activities were targeted at both men and women. Similar to results for women, men’s awareness of other FP methods (44% for implants, 60% for IUD, and 91% for injectables) was higher than their awareness of SDM (26%) (See Figure 2).

**Figure 5. Change in Awareness of FP Methods from baseline to endline among men, baseline and endline**

**PERCENTAGE OF MEN WHO KNEW OF FAMILY PLANNING METHODS**  
**IRH Household Surveys**

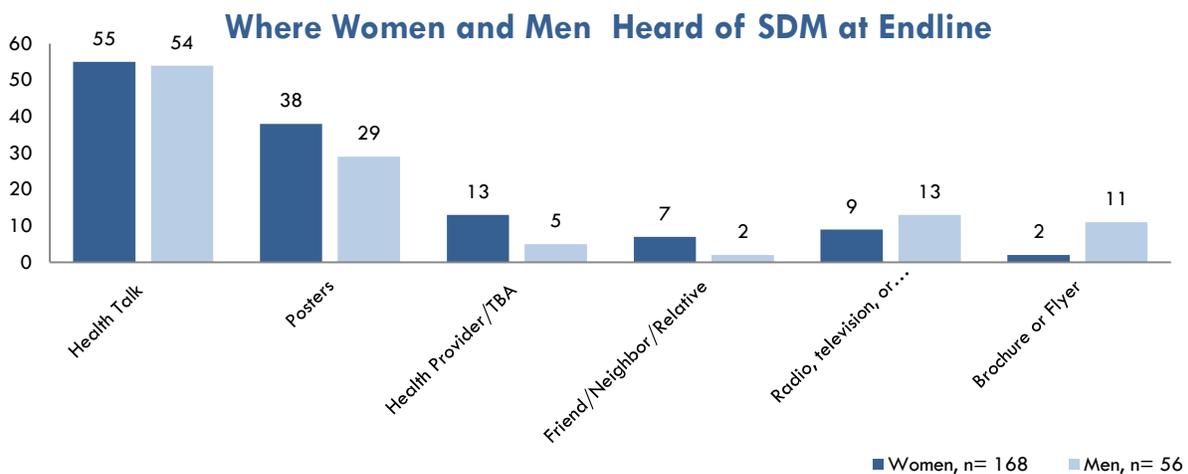


Overall, SDM awareness remains low, showing that numerous small-scale interventions were not sufficient to increase awareness of SDM to the level of other FP methods during the scale-up period. Analysis of household survey data reveal sources of information about SDM (See Figure 3). Men and women reported

that they had mostly heard of SDM through health talks and posters at health centers. Many women also stated they heard of SDM from health providers and 15% of men who responded said they heard about SDM through radio.

Though focused on SDM scale-up, the FAM Project also included efforts to expand access to and increase awareness of LAM. An unexpected finding from the household surveys was that awareness of LAM among both women and men decreased from baseline to endline. This may indicate that LAM awareness-raising efforts did not have their intended impact. It is also possible that women and men learned about LAM but continued to confuse it with breastfeeding, or that they did not readily recall it as a FP method because it is a short-term method that can only be used post-partum.

**Figure 6. Where men and women heard about SDM at endline (IRH household survey)**

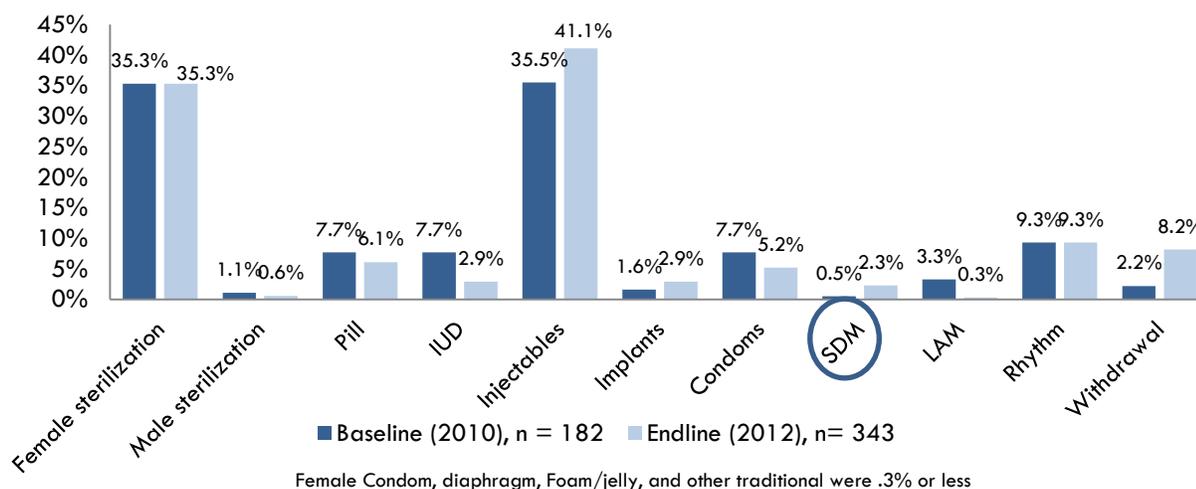


Women were also asked about their opinions of SDM. At both baseline and endline, 54 percent of women who knew of SDM thought the method was difficult to understand. At endline, the percentage of women who thought the SDM was effective (50 percent versus 41 percent) and economical (77 percent versus 67 percent) increased. While women’s perceptions of SDM improved over the scale-up period, more effort is needed to improve attitudes towards the method. Although messages disseminated during IEC activities stated SDM was effective, easy to use and economical, women’s perceptions of SDM’s effectiveness may also be influenced by knowing others who use SDM effectively, but many women do not know anyone using SDM. Women may also think SDM is difficult to use due to the number of instructions (moving the ring, marking the calendar, etc.) that they must follow compared to non-user directed methods. The percentage of women at endline who thought SDM had side effects or caused health problems decreased from baseline.

In relation to use, at baseline, no survey respondents were using SDM, but by endline 2.3 percent of women reported using SDM. The proportion is small, but represents an important gain in the two years between assessments, given that only 35 percent of women had ever heard of the method at endline. Overall, 72 percent of female respondents reported FP use at endline, significantly higher than the national average of 54 percent<sup>8</sup>.

The most commonly used methods were injectables and female sterilization; SDM use was similar to IUD and implant but lagged behind pills and condoms (See Figure 4). At endline an important percentage of women also reported use of rhythm (9.3%) and withdrawal (8.2%), suggesting there is still a need for SDM information among women using traditional FP methods.

**Figure 7. Method Use Among Women Currently Practicing Family Planning (Baseline and Endline)**



Almost half of women using SDM received counseling and/or CycleBeads from a MOH center (45%), followed by a private clinic (18%) or a TBA, APROFAM or community health worker (9% each). This result is not unexpected given the emphasis on working with the MOH throughout scale-up.

Another source of information on current SDM use comes from service statistics from the MOH and APROFAM. Table 7 below indicates the cumulative number of women accepting SDM in the three departments during the scale-up period.

**Table 7. SDM service statistics for MOH and APROFAM for scale-up period**

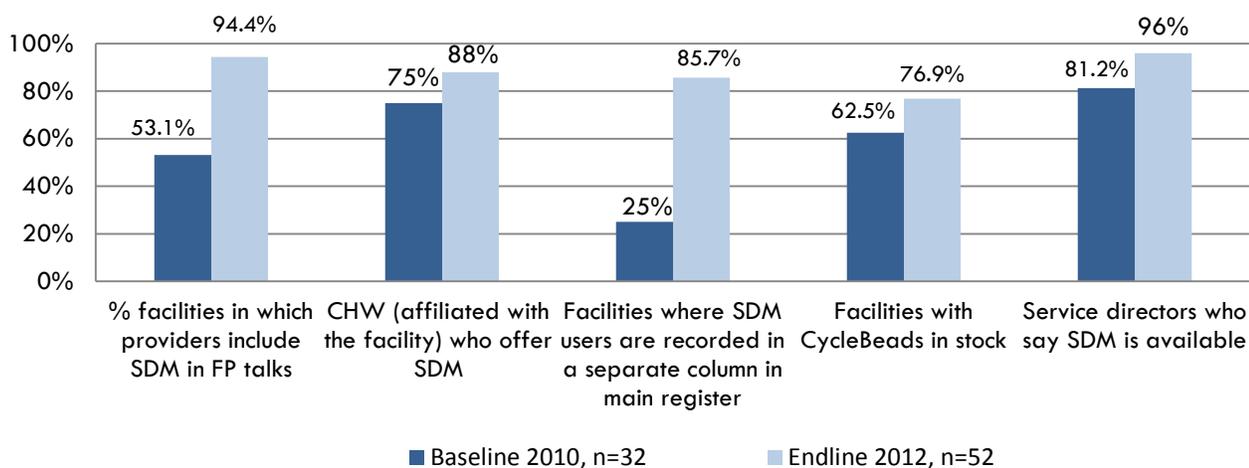
	Year 1	Year 2	Year 3	Year 4	Year 5/6
Number of Women Accepting SDM (MOH and APROFAM service statistics)	911	1,879	2,757	2,873	3,175

Use of Most Significant Change methodology provided insight into SDM use. The methodology used story collection to ask users, providers and program managers what the most significant change in their life had been since using, providing or integrating SDM. A key theme documented through MSC was SDM users' satisfaction with a side effect-free FP option, their husbands' support of SDM use, and increased communication with their spouses. Program managers mentioned increased use of natural FP, especially by women whose religion discourages them from using other methods, and the improved image of their FP program due to expanded method choice. Service providers noticed an increase in FP users and commodity sales, and appreciated the opportunity to expand their knowledge of fertility and to offer a natural FP option to their clients.

## Availability

A comparison of the facility assessments at baseline and endline found that SDM availability had increased in all areas surveyed, as had all direct measures of service provision. The chart below shows select endline results on service provision. According to these results, SDM is integrated into 94-96% of facilities.

**Figure 8. Selected service provision results (IRH Facility Surveys)**



At endline, CycleBeads were available in 77% of health facilities according to facility assessments. As part of monitoring and supervision activities, IRH also conducted phone interviews with facilities in the three departments in 2012 to learn more about CycleBeads inventory at MOH facilities, specifically the number of CycleBeads available at each facility. Results showed that of 160 facilities in the three departments, only 64% had one or more set of CycleBeads available for counseling. Table 8 details the results of these interviews. This suggests that CycleBeads stock-outs are a continuing challenge.

**Table 8. CycleBeads inventory in sample of MOH facilities (IRH CycleBeads Inventory Interviews)**

	Quetzaltenango N=81	Santa Rosa N=36	Solola N=43
At least one set of CycleBeads in stock	58 facilities	21 facilities	27 facilities
% with CycleBeads in stock	72%	58%	63%
Average number of CycleBeads in stock	6	3	6

These data on SDM awareness, attitudes, use and availability help explain why SDM demand remained low throughout scale-up:

- **Lack of awareness of SDM:** Community-based IEC interventions did not result in significant increased awareness about SDM. Several reasons may explain this result, including a need for

greater media coverage, failure to incorporate SDM in social marketing initiatives, and not investing in the right partnerships (See Conclusions).

- Perception that SDM was difficult to use: Results from the endline assessment suggest that women who knew of SDM considered it difficult to use. This could be due to the quality of information provided on SDM or not being accustomed to user-directed methods. Either way, lukewarm perceptions about SDM may have affected the method's uptake.
- Limited availability of CycleBeads: Limited availability of CycleBeads may have resulted in potential users leaving without a commodity, especially in Santa Rosa. According to the endline, 25 percent of facilities had no CycleBeads during the assessment and inventory in the three departments showed greater problems with CycleBeads stocks.

## Differences Between Departments

It should also be noted that there were some significant differences between results found by department. For example, in Quetzaltenango there was evidence of strong SDM integration in training, logistics and procurement and HMIS in health centers (at endline). Directors interviewed during facility assessments reported the following:

- SDM is available in their health centers (100%)
- At least one provider is trained to offer SDM (100%)
- Providers offer SDM daily along with other FP methods (100%)

Results for CycleBeads availability were also more positive in Quetzaltenango than the other two departments according to facility assessments and CycleBeads inventories.

However, it seems that availability of SDM counseling and CycleBeads in health centers in Quetzaltenango did not translate into increased awareness and uptake of SDM in that department. The greatest levels of awareness and use of SDM were found in the department of Solola. Here, 51 percent of women and 35 percent of men interviewed were familiar with SDM; and seven percent of women were currently using SDM. Meanwhile, Santa Rosa showed the poorest integration of SDM and consequently the weakest results across most indicators.

## Conclusions

Scale-up efforts carried out by IRH and its partners were substantial, and results showed important achievements. However, scale-up efforts were not without challenges or lesson learned, as discussed below.

## Key Factors that Facilitated and Impeded Scale-Up Efforts

The government of Guatemala managed several programs designed to reduce the marginalization of indigenous populations and this commitment ultimately supported advocacy efforts to expand access to FP and SDM to community-level services. **Prioritizing community-level service provision provided an additional platform for SDM expansion** and highlighted the benefits of SDM as a low-cost option. In addition to bringing attention to the need for expanding FP access for rural communities, community-level service provision addressed inadequate access to FP for indigenous populations. Efforts to raise awareness of SDM and FP through radio programs in native languages and offer FP through TBAs are examples of how community-level service provision and outreach was addressed during scale-up.

Overall, results from the evaluation of SDM scale-up efforts suggest a stronger focus on vertical than horizontal integration. Undoubtedly, SDM inclusion into national policies, norms, and guidelines, as well as in-service and pre-service curricula was an important achievement in securing the method's integration and sustainability in FP services and programs. Meanwhile, IRH field staff dedicated a great deal of time to advocacy with the MOH, APROFAM and other NGOs for SDM integration. However, these accomplishments were not sufficient to support wide SDM expansion or horizontal integration during scale-up. SDM awareness continues to be relatively low and the future availability of CycleBeads remain uncertain until the MOH procures them. There are several reasons that may explain these outcomes:

- While numerous IEC activities were initiated by IRH during scale-up, **SDM awareness-raising was not taken on by organizations with significant reach** such as APROFAM and MOH/PROEDUSA, among others. IRH may not have invested enough time and resources in these partnerships. Private organizations such as FGER and TIGO shared costs of several interventions, but the ability to reach a national audience in a sustainable and cost-effective manner lies with organizations that regularly conduct promotional and awareness-raising activities for SRH.
- Community-level integration was a key component of the SDM innovation in Guatemala and IRH field staff worked closely with MOH Health Areas in the three departments, but **a field presence could have facilitated activities, monitoring and supervision efforts and ultimately greater integration of SDM.**

In Guatemala, SDM scale up was jointly designed by IRH and the Resource Team, but it was still important to seize political opportunities and use national priorities to move SDM along the horizontal scale up axis. **The reemergence of the Law on Universal and Equal Access to FP Services created a dialogue in Guatemala about the importance of informed choice** and energized women's groups and FP organizations, including those in the Resource Team, to demand a full array of methods in FP services, including SDM. National attention given to indigenous populations, who have poorer health outcomes, also played a role in advocating for reaching these populations with a natural method, well-suited to distribution in rural settings or through community-level channels.

In both the pilot and scale-up phase, **involvement of multiple stakeholders was crucial for obtaining buy-in for specific interventions and related advocacy.** Partners, especially the MOH's PNSR, were deeply involved in defining the innovation and designing the scale-up strategy, so it was no surprise that they took on the responsibility of leading the Resource Team when a scale-up strategy was developed. Leadership from the MOH helped secure participation from other key FP organizations, through the Resource Team. Not only did partners and Resource Team members join in advocacy for SDM integration (into new materials, guidelines, capacity-building activities, etc.), they took shared responsibility for outcomes.

**A weak public-sector M&E system meant health systems strengthening work was needed,** before SDM could be integrated into the system. IRH and the Resource Team helped the MOH's PNSR develop and validate FP supervision and logistics tools, which were needed to monitor access, availability and quality of MOH services. The weak M&E system resulted in gaps in knowledge among MOH officials about the reality of FP access in certain departments and lack of clarity on what barriers needed to be resolved to improve flow of information, increase distribution of commodities and standardize processes. Through the Resource Team, IRH also supported capacity building activities related to M&E and M&E visits. It was only through these activities that SDM scale-up in relation to quality services could be assessed.

These issues call attention to the importance of a *systematic approach* to full integration. Building capacity, creating demand and advocating for SDM's inclusion in normative documents must go hand in hand with advocating for procurement and monitoring a methods' availability within service delivery programs.

## Sustainability of SDM in Guatemala's FP Programs

While significant progress has been made across various components to scale up SDM at the national level, Guatemala is at a critical point. *Will efforts to expand SDM to the national level occur, given the evidence from the three focus departments, greater capacity to offer SDM at scale, and political will built from collaborative scale-up efforts?* To assure that these achievements are sustained and/or advanced upon, key actors and strategies have been identified, that will move SDM forward in terms of advocacy, capacity building, logistics and procurement, IEC, and HMIS and M&E.

**Table 9. Actions needed for SDM sustainability, by component and responsible party**

SCALE-UP COMPONENT	ACTION FOR SUSTAINABILITY	RESPONSIBLE PARTY
<b>ADVOCACY</b>	<ul style="list-style-type: none"> <li>Advocate for inclusion of FAM as new materials are developed and guidelines, protocols and surveys are updated</li> <li>Incorporate the SDM Integration Toolkit under the MOH website</li> </ul>	<ul style="list-style-type: none"> <li>Resource Team</li> <li>MOH National SRH Program</li> </ul>
<b>CAPACITY BUILDING</b>	<ul style="list-style-type: none"> <li>Maintain resources and provide technical assistance to expand SDM capacity building activities nationally</li> <li>Maintain SDM online course on MOH website</li> <li>Continue offering SDM self-study course</li> </ul>	<ul style="list-style-type: none"> <li>Resource Team organizations</li> <li>MOH Training Department (DECAP)</li> </ul>
<b>LOGISTICS AND PROCUREMENT</b>	<ul style="list-style-type: none"> <li>Support CycleBeads distribution in the public and private sectors.</li> <li>Collaborate on procurement of CycleBeads</li> </ul>	<ul style="list-style-type: none"> <li>APROFAM</li> <li>MOH, APROFAM</li> </ul>
<b>IEC</b>	<ul style="list-style-type: none"> <li>Use and incorporate SDM IEC resources (e.g. radio programs, invitation cards etc.) into project activities</li> </ul>	<ul style="list-style-type: none"> <li>USAID bilateral members</li> <li>MOH National SRH Program</li> </ul>
<b>HMIS/ MONITORING &amp; EVALUATION</b>	<ul style="list-style-type: none"> <li>Institutionalize FP M&amp;E supplemental instrument developed by the Resource Team</li> <li>Provide financial assistance for M&amp;E visits to public/private health posts</li> <li>Conduct M&amp;E visits to public and private sector health posts</li> <li>Include SDM in 2014 DHS</li> </ul>	<ul style="list-style-type: none"> <li>MOH National SRH Program</li> <li>Resource Team</li> <li>USAID bilateral members</li> <li>USAID/Guatemala Mission</li> </ul>

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- <sup>1</sup> Minority Rights Group International, *World Directory of Minorities and Indigenous Peoples - Guatemala: Maya*, July 2008. <http://www.unhcr.org/refworld/docid/49749d163c.html> [accessed 12 February 2012]
- <sup>2</sup> The World Factbook 2009. Washington, DC: Central Intelligence Agency, 2009. <https://www.cia.gov/library/publications/the-world-factbook/geos/gt.html> [accessed 11 February 2012]
- <sup>3</sup> Encuesta Nacional de Salud Materno Infantil 2008 (ENSMI 2008-2009). Ministerio de Salud Pública y Asistencia Social /Instituto Nacional de Estadística (INE)/Centros de Control y Prevención de Enfermedades (CDC). Guatemala 2010. Pp. 127.
- <sup>4</sup> ENSMI 2008-2009. Pp. 122.
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- <sup>6</sup> Burkhart M, et al. Effectiveness of a Standard-Rule Method of Calendar Rhythm among Mayan Couples in Guatemala. *International Family Planning Perspectives*. Vol. 26, No. 3 (Sep., 2000) 131-136.
- <sup>7</sup> M. Arevalo, et al. Efficacy of a new method of family planning: the Standard Days Method. *Contraception*. 65 (2002) 333-338.
- <sup>8</sup> ENSMI 2008-2009. Pp. 127.