

Fertility Awareness-Based Methods: End of Project Final Report

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Georgetown University



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

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

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Acronyms

AFR	Action Familiale Rwandaise
ARBEF	Association Rwandaise pour le Bien-Etre Familial
BCG	Boston Consulting Group
BOM	Billings Ovulation Method
COP	Community of Practice
CRS	Catholic Relief Services
DHS	Demographic Health Survey
DRC	Democratic Republic of the Congo
EOI3	Each One Invites Three
ESD	Extending Service Delivery
FALAH	Family Advancement for Life and Health
FAM	Fertility Awareness-based Methods
FBO	Faith-based Organization
FP	Family Planning
FRHP	Focus Region Health Project
GHS	Ghana Health Service
HIP	High Impact Practice
HMIS	Health Management Information Systems
HTSP	Healthy Timing and Spacing of Pregnancy
IBP	Implementing Best Practices
IEC	Information, Education, and Communication
INGO	International Non-Governmental Organization
IPPF	International Planned Parenthood Federation
IRH	Institute for Reproductive Health, Georgetown University
ISHP	Indian Society of Health Professionals
IUD	Intrauterine Device
IYWG	Interagency Youth Working Group
JSI	John Snow International
KIT	Knowledge Improvement Tool
LAM	Lactational Amenorrhea Method
M&E	Monitoring and Evaluation
MCB	My Changing Body
MCHIP	Maternal and Child Health Integrated Program
mHealth	Mobile Health
MICYN	Maternal, Infant and Young Child Nutrition
MLE	Monitoring, Learning and Evaluation
MOH	Ministry of Health
NFP	Natural Family Planning
NGO	Non-governmental Organization
NGO	Non-Governmental Organization
P4RP	Planning for Responsible Parenthood
PMP	Performance Monitoring Plan
PSI	Population Services International
PVO	Private Voluntary Organization
RH	Reproductive Health
SDM	Standard Days Method
SMS	Short Message Service

SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TAG	Technical Advisory Group
TIPs	Trials of Improved Practices
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VYA	Very Young Adolescent
WHO	World Health Organization
YWCA	Young Women's Christian Association

I. Global-level achievements and what remains to be done

Overview

Throughout the FAM Project, Georgetown University's Institute for Reproductive Health (IRH) provided sustained, proactive technical leadership and advocacy at the global level to establish credibility and cultivate broad support for including fertility awareness-based methods (FAM) in family planning (FP) and reproductive health (RH) programming. Our primary leadership goal was to establish positive, evidence-based perceptions of FAM, creating a constituency to support their inclusion in programs and mobilizing resources to support FAM. We accomplished this goal by building partnerships with key individuals and organizations in a position to act on the evidence resulting from our research (e.g., provide funding for FAM, include FAM in their policies and programs) and to involve others (e.g., include FAM in state-of-the-art documents, provide information through their networks).

As the FAM Project developed, a second leadership goal emerged: to develop and share evidence about the process of scaling up a RH intervention. Much of the research described in IR2 of this report focused on scaling up FAM in five countries. In addition, interest grew in the "science" of scale-up during the FAM Project, and IRH's experience was a key contributor to this discussion. The final two years of the project involved extensive engagement with the global FP/RH community around this issue. IRH staff provided input into global guidance documents on scale-up, gave presentations on papers at scientific conferences, and participated in technical working groups. By the end of the FAM Project, IRH had made significant contributions to the science of scale-up.

Throughout the project, IRH achieved steady progress on each indicator identified by the Project Performance Monitoring Plan (PMP). The following indicators, developed at the beginning of the project, tracked the global leadership component of our work:

- Number of international and regional meetings including presentations on FAM;
- Number of global partners disseminating FAM information and products;
- Number of global partners incorporating FAM into programs, training, population surveys, and policies;
- Number of publications on FAM and references to FAM in print and electronic (internet-based) publications;
- Number and type of channels utilized for dissemination of FAM information; and
- Number of CycleBeads® procured by organization and country.

While specific indicators of global leadership of scale-up are not included in this list, these indicators all track what needs to be in place for bringing an intervention to scale.

The following narrative provides an overview of our global leadership activities and accomplishments over the life of the FAM Project, including technical leadership, resource mobilization and communications.

Technical Leadership

Consultations, Conferences and Working Groups

Consultations, conferences, and working groups provide a forum for dissemination and discussion – key to engaging the global community in issues of mutual interest. Following are examples of IRH’s work in this area.

International Conferences on Family Planning (Uganda, Senegal and Ethiopia)

IRH’s growing role in these landmark conferences, held in 2009, 2011 and 2013, demonstrate the increasing awareness of the importance of our work and its contribution to progress in global FP/RH. In Uganda, IRH presented five papers on topics ranging from “FAM and Gender” to “FP via Mobile Phones in India.” We offered a workshop on FAM, emphasizing the steps for successful integration of FAM into FP/RH programming. For the Senegal and Ethiopia conferences, IRH served on the international scientific steering committee, increased the number of presentations to nine in Senegal and 15 in Ethiopia, and offered a wider range of workshops (focusing on youth, scale-up, and FAM). At the Ethiopia conference, at least nine presentations by non-IRH participants included FAM, indicating a broadening interest in this topic. See a list of these and other conferences in which IRH has participated over the life of the FAM Project (more than 100 in all), including topics presented, in [Appendix A](#).

Engagement with WHO

IRH continued to participate in World Health Organization (WHO)’s Policy and Coordinating Committee of the Human Reproductive Program, using this opportunity to engage with a number of individuals and departments at WHO whose work addresses issues of interest to the FAM Project. Issues include youth, gender, implementation science, scale-up of FP/RH interventions, and up-dating of the “four cornerstone” documents that form the basis of global guidance on FP methods. Illustrative results of IRH’s engagement with WHO include WHO’s advisory note on CycleBeads procurement, which is posted on their website; participation by IRH in a consultation at WHO on state-of-the-art in contraception, at which we presented the latest evidence on FAM generated by IRH and others; and on-going involvement in the Medical Eligibility Criteria revisions. We also participated in the WHO meeting on Very Young Adolescents (VYAs), which contributed to WHO’s efforts to focus research on this vulnerable group.

Technical Working Groups

IRH participated in several working groups organized by United States Agency for International Development (USAID), including Monitoring and Evaluation (M&E) of Scale-up, the Scale-up Community of Practice (COP), the High Impact Practices (HIP) Technical Advisory Group (TAG), the CORE Group, the Maternal, Infant and Young Child Nutrition (MICYN) Working Group, and the Mobile Health (mHealth) Working Group ([Appendix B](#) for complete list). Our contributions to these efforts include:

- “Defining a Practice”, a section of the M&E of Scale-up Tool Kit,
- A webinar on M&E of Scale-up, the first webinar of the recently-formed COP,
- Reviews of HIP documents and strategic planning discussions,
- Incorporating FAM in the programming of several CORE Group organizations,
- Evidence-based programmatic guidance on LAM designed to increase access, utilization and measurement, and

- A focus on iterative testing of mHealth interventions; complexities of user-focused, interactive mHealth services; and marketing and sustainability.

IRH Conferences and Technical Consultations

Having generated findings in several emerging RH issues, the FAM Project convened six technical consultations with global experts to present this evidence and develop an agenda for the way forward. These consultations included: Involving Men in FP/RH Programs; the TwoDay Method®, a New and Effective Fertility Awareness-based Method of Family Planning; Strategies for Monitoring, Learning, and Evaluation of the Scale-up Process; Fertility Awareness and its impact on RH Outcomes; Sexual and Reproductive Health of Very Young Adolescents; and Promising Practices for Scaling up a Health Innovation.

[A Systems Approach to the M&E of Scale-Up](#)

The technical consultation brought together 30 program practitioners and researchers to: foster thinking on practices for monitoring processes and evaluating outcomes of scale-up of health innovations; articulate in practical terms the gaps and opportunities for improvement of the practice of M&E of scale-up; and offer input into products that IRH should develop for wide dissemination that will contribute to advancing good practice on M&E of scale-up, including feedback on M&E tools developed by IRH for the case study on scaling up Standard Days Method® (SDM).

Consultation on the TwoDay Method of Family Planning

In November 2012, IRH brought together experts in the areas of family planning, contraceptive development, biomedical science, reproductive physiology, gender and service delivery to discuss the TwoDay Method of FP—reviewing its development over the last decade and current studies, and identifying a trajectory for future work. As developers of the method, IRH presented their research to date, and the existing evidence was reviewed together as a group. Through a variety of individual and panel presentations, as well as large and small group discussion, key areas were explored, including the importance of evidence base of TwoDay Method, the correlation between vaginal health and fertility awareness, and the potential of direct-to-consumer approaches.

The Big Picture: Viewing Gender, SRH and Very Young Adolescents through a Wide Angle Lens (summary via Interagency Youth Working Group [YouthLens #39](#))

In collaboration with FHI360, IRH co-hosted the 2013 meeting of USAID's Interagency Youth Working Group (IYWG) which focused on programming for very young adolescents (VYAs). This meeting was followed by a half-day technical consultation where leading experts in this field reviewed key outcomes and lessons from the 2013 IYWG meeting. The workshop deliberations and conclusions will inform recommendations for improving the sexual and reproductive health (SRH) of VYAs to guide programming and investment at international, country, and local levels.

Let's talk about fertility awareness: Implications for reproductive health ([Consultation Report](#))

In July 2013, IRH held a technical consultation on fertility awareness and its impact on SRH outcomes. The consultation was informed by a review of the existing literature on fertility awareness which was compiled into a White Paper. The key objectives of the Fertility Awareness Technical Consultation were to: define fertility awareness; assess the evidence of the effect of fertility awareness on SRH attitudes and behaviors across the life course; explore how fertility awareness could contribute to SRH program goals; and identify the knowledge gaps that could be addressed by future research.

Lessons Learned from Scaling up a Reproductive Health Innovation: Implications for Future Work ([Consultation Report](#))

On 25 July, 2013, IRH hosted the last consultation in a series of technical meetings during the final year of the USAID-funded FAM Project. This event showcased the experience and lessons learned from scaling up SDM across five focus countries. Objectives of the consultation were to: share information and lessons learned about scaling up a RH innovation using a systems-focused approach, reflect on different ways of working under donor funded projects to achieve sustainable scale-up, discuss how these lessons learned can help the field develop a better understanding of underlying principles, monitoring, learning, and evaluation (MLE) strategies, and the role of partnerships in scale-up.

Resource Mobilization

Mobilizing resources for FAM continued to be a challenge during the FAM Project. Field support for focus countries was uneven and limited, and leveraging through other USAID-supported projects and projects supported by other donors varied by country (see [Section III](#)). At the global level, while only a few USAID missions and other donors in non-focus countries provided any programmatic support for FAM, numerous organizations included FAM in their guidance documents, tools, and curricula ([Appendix C](#)). In 2010, the World Bank provided a small grant to IRH to support a faith-based organization (FBO) in Kenya to expand their FAM services. Later, as the FAM Project was in its final months, the Bill & Melinda Gates Foundation provided a small grant to support four additional FBOs in Africa.

Communications

Throughout the FAM Project, IRH has implemented a strategy to effectively communicate with a wide variety of audiences to promote greater utilization of project results and encourage support for FAM in research, policy and programs. Our monthly email newsletters (“IRH eNews”) featured FAM Project highlights and new resources to contacts around the world. We continued to use numerous virtual social networking tools, including Twitter, Facebook, LinkedIn, and YouTube, to connect with colleagues, organizations, and those interested in FP/RH. By the end of the project, we had 1,210 followers on Twitter, 650 fans on Facebook, and 35 videos posted on YouTube which collectively have been viewed over 55,650 times.

We disseminated our latest news and most up-to-date resources via our website – www.irh.org – which has sections and resources generated by the FAM Project. We also disseminated information on research and program results through established global networks’ websites and list serves (e.g., CORE Group,

Implementing Best Practices (IBP) Global Community, Communication Initiative, the USAID Development Experience Clearinghouse, and HIPNet).

In addition to responding to hundreds of requests for information over the five-year period, we made a concerted effort to develop and publish communications products that highlighted the FAM Project's contributions to the global health field. A [package of FAM Project briefs](#) were produced to capture key lessons learned.

- Standard Days Method®: Building Gender Equity & Engaging Men in Family Planning
- Doing it Right: Monitoring, Learning and Evaluating for Sustainable Scale-Up
- The Standard Days Method®: A Modern Family Planning Method
- Scaling up a family planning innovation: How health systems are strengthened along the way
- Partnerships with Faith-Based Organizations to Expand Access to Family Planning
- The Lactational Amenorrhea Method(LAM): an important option for mothers and infants gives
- Bringing a health innovation to scale: The story of successful introduction of the Standard Days Method® in Rwanda
- Meeting the Needs of Very Young Adolescents (VYAs) in Rwanda
- Strengthening faith-based partnerships in family planning: Integrating the Standard Days Method® into Catholic health services in Rwanda
- Working with women's associations to increase acceptability and use of family planning in Mali
- TwoDay Method® Community-Based Study

Conclusion

By the end of the FAM Project, IRH had made significant progress toward the two goals of establishing FAM as a key component of FP/RH programming and contributing to the evidence base for scaling up FP/RH interventions. However, challenges remain. For example, while the Demographic and Health Surveys (DHS) now include SDM and LAM as modern methods, SDM remains an “opt in” method, resulting in its exclusion from surveys in a number of countries where it is beginning to be offered. While USAID includes CycleBeads in its commodity procurement system and the AccessRH program lists CycleBeads as an item organizations can procure, in reality there are many countries in which CycleBeads procurement remains a major issue and many organizations that do not have access to them in countries where they are theoretically available. Lack of CycleBeads is a significant impediment to access by those who want to use SDM. SDM is often mentioned in USAID procurements as a method to be included, but it is rarely listed as an “accountability” for program implementers, which limits resources actually being directed to this method. FAM is included in pre-service training in a few countries, and materials are available to train several levels of providers, but capacity and resources to train current and future providers in these methods are limited. There is interest in a number of settings in expanding access to FAM through mobile phone services, but funding to do so has not been forthcoming, and the emphasis on the need for this service to be self-sustaining has so far proven unrealistic. Growing interest in several topics of interest to the FAM Project – e.g., VYAs, scale-up, fertility awareness – is encouraging and a reflection of the importance of IRH's work. Resources will be needed to move forward in these areas. A combination of USAID commitment, foundation support, and the potential for leveraging will be necessary.

II. Promising Practices for Scale-Up: A Prospective Case Study of Standard Days Method® Integration

Location: Democratic Republic of the Congo, Guatemala, India (Jharkhand), Mali, and Rwanda

Time period: 2007-2013

Partners: Various, including Ministries of Health (MOHs), international non-governmental organizations (INGOs), non-governmental organizations (NGOs) and donors in the five countries

Sustainable scale-up of tested interventions does not happen spontaneously but is rather a result of concerted, deliberate efforts to expand availability of the innovation (horizontal scale-up) while institutionalizing it in policies and programs (vertical scale-up). From 2000 to 2006, IRH developed SDM and conducted clinical trials, pilot introductions, operations research, and impact studies in diverse global settings to test SDM. Results of these studies suggested that SDM merited scale-up and also garnered IRH USAID's support for adding a simple, modern, natural family planning (NFP) method to national programs at scale. IRH, guided by WHO's ExpandNet framework, managed to simultaneously (a) scale an effective and attractive new method to reach millions in five countries: Democratic Republic of the Congo (DRC), Guatemala, India, Mali and Rwanda; and (b) conduct a prospective multi-site case study to document, assess, and guide the scale-up process.

Given the unique opportunity to carry out robust scale-up research in five different settings, IRH utilized a prospective, systems-oriented, case study methodology to document not only the scale-up process but also the rich lessons learned regarding the MLE of scale-up. A mixed-methods approach anchored the case study process and facilitated learning in both scale-up implementation and MLE. Ultimately, IRH quantified increases in access to and use of SDM and accomplishments in institutionalization of elements that create an enabling environment for sustainability, and contributed to the growing evidence base on MLE of the scale-up process.

Scale-up Implementation & Results

Key to IRH's work were partnerships with and technical assistance to the Ministry of Health and other key actors including major donors, NGOs, private voluntary organizations (PVOs), community-based groups, FBOs and FP associations in each country. Whether it was in the area of training support, capacity building, advocacy, service delivery, supervision, information, education and communication (IEC), or logistics, the nature of technical assistance was adjusted to suit the particular context and needs of each country. Data sources – including baseline and endline household surveys and facility assessments, stakeholder interviews, service provision and quality audits, client satisfaction follow-up, and benchmarks of horizontal and vertical scale-up – contributed to the analysis of system elements (innovation, user organizations, resource organizations, environment, and the actual scale-up strategy) as well as guiding principles (systems thinking; sustainability; scalability, the suitability of the innovation for scale-up; and a respect for human rights, gender and equity to ensure that quality services are accessible to all). To further maximize scale-up sustainability, IRH engaged in resource mobilization to further scale-up in each country and transferred ownership of SDM capacity-building to local actors.

Each country's scale-up goals were different. While SDM was only institutionalized in Jharkhand state in India, the other four countries chose to undertake national level institutionalization. As for horizontal scale-up, Rwanda and Mali had the potential to achieve near-national provision of SDM; DRC's potential was limited by poor infrastructure, a FP program in the process of revitalization, and the spotty presence of partners on the ground; Guatemala strategically expanded service delivery in three of USAID's focus departments (country has 22); and India's scale-up occurred in the 50 percent of Jharkhand districts with the greatest need for FP services.

Scale-up results span four categories: SDM awareness, SDM use, SDM service availability, and institutionalization. With regards to awareness, *awareness* of SDM increased among women and men in all countries, but remained lower than awareness of other, more established methods (with the exception of Rwanda), an understandable situation given the relatively small resources available for SDM awareness-raising. Sources of information about SDM varied significantly by country; predominant sources were family member or friend in DRC (>50%), health facilities in Guatemala and India (46% and 67% respectively), and television in Mali (81%). All survey respondents who had heard of SDM were then asked their opinion about the method. Of the women who had heard of SDM but had never used it, 51% considered it effective in preventing pregnancy and 52% thought it would be easy to use. In contrast, these figures were 89% and 85% respectively for women who had ever used the SDM, whether or not they were still using the method. The percent of women using FP who opted for SDM at endline ranged from 2.3% in Guatemala to 15.4% in DRC. Most women (74%) who were using the method at the time of the survey were satisfied with it, and 79% were planning to continue using it.

Service expansion or *availability of SDM* increased dramatically over the course of scale-up in all countries. At the end of the study, between 90% (in India) and 103% (in Rwanda) of the anticipated number of service delivery points were offering the SDM. The percentage of providers trained, compared to the goals set initially varies widely (DRC 54%, India 71%, Mali 89%, Guatemala 105%, and Rwanda 138%). In some cases, this is because of unrealistic initial goals, while in others; it is the result of environmental factors (e.g., political turnover, shifting donor emphasis). Scale-up requires *institutionalization* of the innovation into key policies and program support systems. Inclusion of SDM in norms, policies and guidelines as well as in training curricula, both in-service training and pre-service education, were early gains in vertical scale-up. Other gains were limited or non-existent mostly because the scale-up phase did not coincide with the timing for revising national health management information systems (HMIS), procurement/delivery systems and health surveys. The most difficult challenge was to incorporate SDM into some of the government and donor procurement systems and secure their financial commitment to purchase CycleBeads. The USAID | DELIVER PROJECT included CycleBeads in USAID commodities procurement system, which facilitated scale-up in USAID-funded projects/countries. In other countries/areas where other donors (primarily United Nations Population Fund [UNFPA]) procure commodities, CycleBeads availability remained an unresolved problem.

MLE of Scale-Up

Another major outcome of the prospective case study was the development of the Compendium on Promising Practices in Scale-Up Monitoring, Learning & Evaluation¹. There is growing realization that inadequate attention has been paid to systems issues that support successful and sustainable scale-up. Organizations undertaking systems-oriented approaches to scale-up will find few tested, practical tools and guidelines to monitor and evaluate scale-up of an innovation within a complex health system. The compendium was born out of this recognition of the dearth of guidance for best practices to support scale-up efforts despite a wealth of tested, practical methods, tools, and guidelines for planning, monitoring, and evaluating project-based SRH interventions.

Following an assessment of the initiatives IRH used to provide stakeholders timely monitoring information to inform scale-up decisions, learn throughout the process, and evaluate achievements, USAID requested that IRH document guidance on MLE of scale-up. To that effect, IRH conducted a literature review, systematically reviewed its tools and materials, and convened scale-up experts for a technical consultation on the topic. During the one-day session, the experts explored key issues in the scale-up arena, provided input on IRH's materials and unique strengths to contribute to the field, and made suggestions for possible formats for the resource. After the consultation, IRH finalized the compendium, which is organized into three sections of tools arranged according to their primary use—planning, monitoring and supervision, and evaluation. Accompanying each tool is a description of its purpose, how it was developed and used, whether/how the tool was used to collect information on values of the innovation, and lessons learned about what worked and what IRH would do differently going forward.

Guided and informed by the systems-oriented approach espoused in the ExpandNet scale-up framework, the compendium is distilled from knowledge and practical experience doing scale-up MLE. It frames IRH's learning about the critical role of scale-up MLE in the complex messiness of scale-up; and highlights the continuing need for systems thinking and a more complete road map for learning from monitoring and evaluating the introduction *and* scale-up of new FP methods and approaches in the context of FP2020.

Lessons Learned

During, and at the end of scale-up, IRH and its partners learned that:

1. Promising Practices such as a dedicated technical leader, strong and diverse resource team of national and NGO partners, health systems strengthening, innovation simplification, varied and strategic demand creation efforts, strong individual and organizational champions of the method, and leveraging of M&E data helped to nurture and maintain scale-up.
2. Donors influence scale-up in expected and unexpected ways; particularly in their procurement mechanisms, support or undermining of method credibility/legitimacy, and staffing.
3. Partnerships, though complicated at times and varied across countries, promote stakeholder buy-in and contribute to reaching the tipping point for sustainable scale.

¹ Compendium title is Promising Practices in Scale-Up Monitoring, Learning & Evaluation: A Compendium of Resources. <http://irh.org/scale-up-mle-compendium-of-resources/#sthash.Wq0p3iLL.dpuf>

4. Providing quality technical assistance throughout scale-up requires staff skills and perspectives to adjust during various scale-up phases.
5. SDM at scale makes unique contributions to FP programs such as facilitating active participation from FBOs; encouraging male involvement in FP and RH activities through improved couple communication; and supporting the expansion of method mix and choice with new methods rather than replacing other methods.
6. Embracing systems approaches means giving up control of the scale-up process while using guiding principles and core values to lead to wide availability of quality, sustainable services.
7. Monitoring and advocacy are needed to maintain gains that may be reversed in evolving systems.
8. Sustainable scale-up requires balancing the need for horizontal results with the need for vertical results.

Scale-up, a complex process involving many actors and contributing factors, requires time, resources and a positive attitude. While it may be frustrating, approaching it systematically, using M&E to learn and guide decisions, and focusing on the transfer of capacity and responsibility from resource to user organizations can result in successful –and lasting – scale-up. The case study, just as the scale-up effort, contributed to the global body of knowledge on how to expand, measure, and sustain worthy health innovations.

III. Regional Integration, Technical Assistance and Strengthening of FAM

As IRH is generally recognized as the primary technical leader in FAM, our assistance was requested by a number of cooperating agencies and local partners that embraced efforts to incorporate new or strengthen existing SDM services in local programs. As a result, SDM is now available to a limited extent through public sector programs in Kenya and Burundi (FHI), Ghana (John Snow International [JSI]), East Timor (Catholic Relief Services [CRS]), Angola (Pathfinder), Benin (Population Services International [PSI]) and Zambia (Salvation Army).

Efforts to integrate SDM (and LAM selectively) in non-focus countries were possible under FAM with limited support from IRH headquarters and continuous on-the-ground assistance from its regional staff. IRH field staff from DRC and Rwanda, already experienced in SDM introduction and scale-up, served in an advisory role, assisting with initial advocacy and sensitization of stakeholders, conducting training of trainers, and providing remote technical assistance to IRH partners. Integration efforts were guided by formative research and/or reliance on the ExpandNet model. An important aspect of IRH's support for SDM integration involved creating bridges between organizations and the donor support systems for commodities procurement, as a means of ensuring availability of CycleBeads beyond the quantities donated for project start-up activities.

Guinea 2008-2011 – Pathfinder ESD Project

IRH and Extending Service Delivery (ESD) Project conducted a small-scale introduction of SDM in the Guinean MOH's FP program and systems in three areas, Faranah, Kankan and Nzérékoré. While SDM was

integrated into only one-fifth of health facilities and community-level services in the three ESD Project areas, at the end of the 14-month period, the method had been integrated into MOH norms and guidelines, pre-service and in-service curricula, and IEC and supervision materials.

Benin 2009-2011 – FHI360 C-Change Project

To strengthen SDM services previously introduced in the early 2000s under the AWARENESS Project, IRH in 2009 collaborated with FHI360's C-Change Project to test the effectiveness of a direct-to-consumer approach for SDM. IRH provided technical assistance to FHI360 to design an approach for delivering a paper tool to use SDM and conduct a small study that assessed the uptake of the final paper SDM in urban and peri-urban neighborhoods of Cotonou. The paper image was and continued to be used as a promotional tool to increase awareness of SDM and facilitated wide dissemination beyond traditional service delivery points.

East Timor 2009 - Planning for Responsible Parenthood (P4RP)/CRS

CRS funded IRH under the P4RP project in East Timor to help respond to national priorities for meeting Millennium Development Goals (MDG) among which was the development and adoption of a National Family Planning Policy. IRH's assistance contributed essential options to the full range of RH services with the SDM and LAM. Baseline assessments were critical for identifying factors that would support or hinder the introduction of these methods in an environment that was highly controversial. IRH's technical assistance helped CRS tailor and guide advocacy to promote access to child spacing and NFP services, identify and work with champions in various sectors and implement efforts to create services linkages between the MOH and the Catholic Church.

Burundi 2010-2011 - FHI360 ROADS Project

IRH supported FHI 360's efforts under the Regional Outreach Addressing AIDS through Development Strategies (ROADS) Project to expand the method mix to include natural methods. IRH's technical assistance for this pilot introduction in four sites in northern Burundi included adapting training materials and job aids for the Burundian context, training on fertility awareness and SDM, as well as gender and sexuality counseling, post-training follow-up supervision, a second training on concepts and integration of gender and male involvement into FP and SDM counseling services. SDM's contribution during the short pilot introduction among the other FP methods offered in the pilot sites was 3.26% where 73% of clients who chose SDM had not used a FP method before. FHI/ROADS continued to include SDM in areas where they were working, and scale-up in 2011 was extended from four pilot sites to 16 sites.

Ghana 2010-2013 - Ghana Health Services (GHS), Focus Region Health Project (FRHP)

With support from USAID/Ghana, IRH supported the JSI-lead bilateral health programs to integrate SDM in 60 sites in six districts as well as the systematic monitoring of services and a final assessment of the pilot efforts. IRH's technical assistance was directed at developing provider capacity and guiding procurement and logistics decisions for securing CycleBeads. Provider competency was carefully monitored, and method introduction efforts were evaluated jointly with involvement of Kumasi Nkrumah University of Science and Technology (KNUST).

Angola 2009-2010 – Pathfinder ESD Project

Collaboration with Extending Service Delivery Project (ESD) in Angola was guided by results from IRH's baseline assessment to determine the level of readiness of the local program to introduce the SDM and LAM. Technical assistance to ESD and local partners resulted in inclusion of SDM in national norms, SDM and LAM IEC material adaptations in Portuguese, and the integration of these methods at various program levels, including training, supervision, service protocols, education and outreach, and logistics. Procurement of CycleBeads by USAID locally helped facilitate SDM integration in the localities targeted by ESD in the Province of Landa. Also, IRH's technical assistance to ESD helped strengthen that project's local work around the Healthy Timing and Spacing of Pregnancies (HTSP) initiative and contribute to the national FP program method mix with a natural method more widely accepted by a largely Catholic population. Indicators of FAM integration were added to ESD's PMP for routine monitoring beyond IRH's intervention.

Pakistan 2009 – The Population Council's Family Advancement for Life and Health (FALAH) project

IRH supported one of FALAH's objectives of repositioning FP through the introduction of SDM. IRH's technical assistance involved supporting advocacy efforts to remove barriers and improve understanding of NFP among clinicians; building provider capacity through a national training of trainers and revision of local curricula to include SDM and assisting FALAH develop a distribution plan for CycleBeads imported by that project. SDM integration was kept as one of FALAH's activities during the life of the project, thus enabling diffusion of the method beyond the pilot intervention sites.

Bolivia 2009-2011 – USAID/Bolivia and local NGOs

IRH's technical assistance to the USAID/Bolivia-funded ENLACE en Salud project built on past experience with SDM introduction to further consolidate local capacity for FAM among MOH and other local organizations through advocacy with stakeholders; training of master trainers; integration of FAM indicators in monitoring and evaluation; and supporting contraceptive security through availability of CycleBeads for the SDM and a client card for LAM. A key FAM effort in Bolivia was securing CycleBeads availability in country through PROSALUD, the local International Planned Parenthood Federation (IPPF) affiliate, and in the national procurement and distribution system. IRH support to ProSalud involved establishing a revolving fund with donated CycleBeads that later helped them continue to import, distribute and socially market the product. Local capacity for training also was established through a regional School of Nursing to offer the SDM self-study course within their continuing education

Kenya 2009 – AIDS, Population, and Health Integrated Assistance Project (APHIA) II NEP, Kenya's Division of Reproductive Health (DRH), FHI360

Between January and June 2009, 254 clients of seven health facilities in Ijara accepted SDM and were given CycleBeads. Of this group, most were Muslim (95 percent), female (97 percent), and married (97 percent). Their average fertility rate was 4.3, and their average age was 27 years old. Most (93 percent) were new to the use of a modern method. When the SDM acceptors were asked to state their reasons for choosing the method, the top four reasons given were, "it doesn't affect health" (42 percent), "it has no side effects" (38

percent), “religious reasons” (33 percent), and “it is easy to learn/use” (31 percent). SDM acceptors were most likely to have learned about CycleBeads™ from their health providers (91 percent), with a small proportion having received this information from their husbands (4 percent). This introduction of the SDM in Kenya’s Ijara district attracted new users of modern FP methods. Few clients switched to SDM from another method. Providers and clients had positive opinions of the method. However, as the project progressed, some gaps in knowledge were observed among the trained service providers, and concerns emerged regarding adequate commodity supply, the lack of male involvement in managing the method, and language barriers. Based on their experiences, providers believed that the SDM could be scaled up in other districts in the province using the lessons learned from the Ijara pilot. Providers cautioned that successful scale-up would depend on adequate community sensitization, equipping providers with appropriate supplies of job aids and client education materials, supplying enough CycleBeads™ to meet demand, and training providers and backing them up with supportive supervision.

More limited technical assistance efforts to USAID cooperating agencies involved working with PSI in **Mozambique** to develop the Portuguese version of the CycleBeads insert for social marketing sales. Distance technical assistance was provided to the USAID health bilateral in **Malawi** by hosting a Malawian delegation of MOH and project staff for three days in Rwanda.

IV. FAM Research Studies

Introduction

The research agenda of the FAM Project was designed to build upon the experience of previous USAID-funded projects, in which IRH developed, tested and introduced FAM in diverse FP programs in over 20 countries worldwide. With continued emphasis on research-to-practice, the FAM Project engaged partners at the community, national, and international levels to develop and test innovative and replicable strategies to expand access and improve quality of services. During FAM, IRH conducted over twenty studies, in addition to the five-country, six-year prospective case study of FAM scale-up described in the previous section. These research initiatives were selected to support sustainable expansion of FAM globally, and particularly in focus countries.

IRH applied an implementation science lens to FAM research, focusing efforts and resources not only on generating evidence, but also on the uptake, translation and implementation of evidence into practice. While work took place primarily in the five focus countries, our goal was to create generalizable knowledge that could be applied across settings to inform the FAM introduction and expansion. Study design and methods, as well as implementation and dissemination strategies were designed to encourage stakeholders to act on the evidence and inform practice patterns within their settings.

FAM research was also guided by systems approaches to introducing and expanding innovation. Thus, formative research, intervention design and monitoring and evaluation methods sought to consider the entire system within which our work was embedded. This perspective shaped our rigorous mixed-method approach. We sought to use monitoring and evaluation techniques creatively and flexibly, in order to

support the research-to-practice continuum, taking advantage of participatory, qualitative methods such as Most Significant Change, to measure unanticipated results and qualitative aspects of change, and to ensure that the views of women and men, policy makers, donors and program managers involved in the research are taken into account.

A final commonality across most FAM research was the application of an iterative client- and system-centered approach to intervention development and testing. This strategy was used, for example, in the development of the mHealth approach to SDM, CycleTel™, which employed focus groups, in-use testing, manual testing and key informant interviews, with adjustments at each stage, to develop a mobile application for SDM use. In a similar process, IRH collaborated with FHI360's C-Change Project to test the effectiveness of a paper tool to use SDM in urban and peri-urban neighborhoods of Cotonou, Benin. Formative research guided development of an initial prototype which was then modified in small-scale field tests of the prototypes. The final phase assessed uptake of the final paper SDM tool in a community-based field test.

Although many of the issues explored in the FAM research were cross-cutting, the studies can be classified into three categories, and included research designed to:

- 1) inform **systems-based approaches** to introduction and expansion of SDM, LAM and the TwoDay Method;
- 2) expand access to FAM by testing strategies **to reach under-served populations and developing direct-to-consumer approaches** to family planning; and
- 3) explore **gender as a cross-cutting theme** in FAM and develop and test approaches to build a foundation of fertility awareness and gender equity among **adolescents**.

The discussion below provides an overview of the overarching themes and lessons which emerged from this body of research. Summary results and key lessons learned for each of the FAM studies follow, organized according to these three areas.

Theme 1: The value of applying a systems approach to support introduction and expansion of an innovation.

Several studies applied a systems approach to understanding introduction and expansion of SDM, such as the assessment of SDM in the Philippines, which was conducted early in the project and designed to guide scale-up efforts in focus countries. The study concluded that a well-defined scale-up strategy could build support for SDM within the politically-charged context of FP, decentralization, and USAID transfer of contraceptive procurement to the government. Although many FAM studies tested a discrete intervention, such as a user card for women using LAM or guidelines for postpartum SDM users, a common conclusion was the need to address other elements of the system for the intervention to be effective. For example, a study comparing integrated and stand-alone LAM and SDM provider training found that the two options were equally effective, however, CycleBeads stock-outs and lack of provider reinforcement and supervision hindered service delivery. This was also the case in the study testing a LAM user card in Guatemala.

An important element in a systems approach is creating awareness of and demand for a new product or service. Several studies tested demand creation strategies, such as internet Facebook and Google ads,

magazine advertisements and community mobilization. Leveraging the Internet and mass media, IRH explored the feasibility of offering CycleBeads directly to consumers through the promotion of CycleBeads in full-page advertisements in popular magazines. The magazines featured a tear out image of CycleBeads that could be used by women to screen for SDM eligibility and identify their fertile days. One conclusion emerging from demand creation efforts is that the resources needed to support communication initiatives with sufficient coverage and continuity is beyond the resources that projects such as FAM can garner. Community mobilization strategies which diffuse information through social networks, such as *Each One Invites One*, proved more feasible for IRH and partners to implement, although they were labor intensive.

Social diffusion can play an important role in spreading FP information and ideas, with trusted individuals sharing correct and relevant information through their social networks. IRH adapted a successful campaign tested in Madagascar to the Rwandan context in 2011/2012. Male and female community health workers and community association members favorable to FP distributed cards inviting clients and friends to FP services. This campaign, *Each One Invites Three* (EOI3) was designed to address gendered access to information and services by working with and through women's and men's associations. Results showed a significant increase in number of new FP users in the targeted districts during the campaign compared to six months prior, in contrast to the control districts, which experienced a significant decrease.

Theme 2: Access to quality FAM services can be expanded by proven service delivery approaches and materials designed for a variety of contexts.

Materials available for underserved contexts. In accord with the broad objective of FAM, a number of studies were designed to develop and test approaches to reach women and men poorly served by FP services, due to their stage in life, religious and cultural beliefs, or because of economic, social or geographic barriers to access. During the six years of research, service delivery strategies and materials were developed and tested to provide SDM, TwoDay Method and LAM in a wide variety of contexts. This area of work included, for example, simplification of LAM user criteria, development of a simple instruction card for LAM users and training and provider packages to offer the TwoDay Method to low-literacy couples through community-based organizations, including a simplified tracking tool and accompanying low-literacy teaching materials. The research summaries at the end of this section present the details of these studies and links to the materials are provided in the chapter on legacy tools.

Postpartum women. Because SDM relies on regular menstrual cycles, postpartum women cannot commence method use until their regular cycles resume, making it challenging for them to use SDM. Through a series of studies starting with computer modeling moving through an intervention trial in MOH clinics in Rwanda, IRH tested a set of guidelines designed to help postpartum women avoid pregnancy until they are eligible to use SDM. Results suggest that these guidelines are effective and acceptable to providers and clients, and, when feasible, should be added to SDM services.

Beyond the health center. Developing and testing models for expanding SDM services outside of clinical services was another goal of FAM. As an example, studies on the TwoDay method found that with appropriate training, providers of the Billings method, a secretions-based NFP method offered widely the Catholic Church could provide the TwoDay Method as well, without confusing the two approaches. Similarly, research conducted in Rwanda and Guatemala, in collaboration with the Manoff Group,

demonstrated that community-based organizations without health-focused activities can successfully integrate TwoDay Method provision into their portfolio. Also in Mali, IRH and PSI examined the feasibility of increasing SDM access by providing CycleBeads through small stores or “boutiques” that sell food and household supplies, as well as contraceptives, in rural areas where health facilities may be distant from potential clients.

Print tools for FAM use. Building on work to simplify CycleBeads inserts, IRH developed and tested client support materials for LAM and SDM. The LAM user card was designed to remind breastfeeding women when to start using another method, and also intended to improve reporting of LAM users. In many health facilities around the world, any breastfeeding woman is considered a LAM user. Guatemalan MOH officials conceptualized the user card as a way to improve LAM reporting –only women who met the LAM criteria would receive a card, and be registered as a LAM user. Study results suggest that print tools such as the LAM user card can improve counseling and help users recall method criteria; however implementation requires significant and consistent leadership throughout multiple levels of the system (e.g. resources for printing, logistics, training).

In an effort to offer alternatives to CycleBeads and increase awareness of SDM as a FP option in Benin, a paper tool for SDM use was developed. During the month-long test period, 1761 tools were distributed through 24 salons and 14 kiosks in Ahogbohòuè and Gbégamey. Data from service delivery points confirmed that the paper SDM tool facilitated uptake of CycleBeads, with an increase in requests for FP information during the intervention period, and a decline one month after the activity. Encouragingly, most women with some level of literacy could understand and use the paper SDM on their own, without provider assistance.

Paper tools to support FAM use, rigorously developed and piloted, can be attractive and easy-to-understand, however scale-up presents certain challenges. For example, obtaining resources to print materials and ensure a constant supply is not easy. Contraceptive commodities face significant issues related to stock outs, despite significant technical assistance dedicated to this issue. There is no similar support for print materials. Iterative testing of the insert yielded an improved, more comprehensible version, but most potential users required some explanation to supplement the package insert.

mhealth options to expand SDM use. CycleTel is a Short Message Service (SMS)-based application that enables couples to use SDM using their mobile phone. Developed and tested via a series of studies conducted during FAM, it is the first application to actually deliver a FP method to individuals and couples via mobile phones. Product development began with a proof-of-concept study to determine the acceptability and feasibility of supporting SDM use with a mobile phone service. The study sought to understand mobile phone use patterns; appropriate content, frequency and timing of the messages; whether women would like their husbands to participate in sending or receiving text messages; and how to reach potential users. The results of this testing informed the next stages of technology development, which included pilot testing (focus groups and cognitive interviews) and manual testing. Subsequently, automated testing was successful in validating that the technology generally worked as expected, integrating a helpline into the service, and determining processes for monitoring the service.

Key lessons learned. IRH strove to simplify approaches to providing FAM and to facilitate correct method use with minimal provider contact, in order to expand access as widely as possible. The intensive, iterative testing process employed successfully increased the comprehensibility of materials. However, across all studies, we found it challenging to offer FAM instruction with no provider interaction at all among the most underserved populations, many of whom have difficulty understanding even simple materials. More importantly, perhaps, basic fertility “literacy” which would support method comprehension is largely absent. For example, research conducted with PSI in rural Mali testing SDM as a stand-alone contraceptive product sold in boutiques found that although there was interest in purchasing CycleBeads, some explanation was needed. Until basic fertility awareness and literacy increases, additional support for new FAM users will likely be needed to complement direct-to-consumer approaches such as the paper SDM tool or CycleTel. The help line developed to support CycleTel in India is an example of a successful strategy to support new users.

Despite efforts to develop paper-free mnemonic client tools, in a number of settings women preferred written aids. In research conducted to develop low-literacy TwoDay Method materials, participants showed a strong preference for daily, paper-based memory aids because they were easy to use, had clear instructions and helped women to remember to check secretions every day. Women also felt that these memory aids facilitated improved couple communication during use of the method. Another cross-cutting result related to materials design is the finding that pictorial materials for low-literacy users should be accompanied by descriptive wording to facilitate comprehension. During testing of the CycleBeads insert for boutiques in Mali, for example, the option of a solely pictorial side of the insert was discarded, because participants better understood the messages when the images were accompanied by brief explanations.

Theme 3: Interventions which help to build a strong foundation of fertility awareness and gender equity among very young adolescents are feasible, acceptable and effective.

One of the challenges identified with introduction and expansion of FAM, is the reality that very few adults have adequate information on the basics of fertility awareness. This situation is not likely to change, as youth are rarely taught this information. During FAM’s predecessor project, AWARENESS, IRH was asked by USAID to work with FHI360 to apply its knowledge and experience to teaching fertility awareness to young adolescents. The result of this collaboration was *“My Changing Body: Puberty and Fertility Awareness for Young People, First Edition.”* Formative research was conducted under FAM in Rwanda and Guatemala to guide revision of the curriculum to include a stronger focus on gender and sexuality and to a parent component. Results of the pilot of the revised curriculum indicate that introducing topics of fertility and body awareness while weaving in gender and sexuality is an effective way to improve knowledge and increase social awareness, and leads to more healthy behaviors of boys and girls and their parents or adult guardians. As one of the first documented SRH interventions for this age group, this research has paved the way for the growing global interest in development of effective, feasible and replicable strategies focusing on this neglected age group.

Building on this work, IRH continued to develop and test programs for VYAs, seizing the opportunity to intervene before most youth become sexually active and gender roles and norms with negative SRH consequences become solidified. In Nepal, IRH evaluated *“Choices,”* an innovative behavior change

intervention to for VYAs developed and implemented by Save the Children. The results of the evaluation, which used a pre-posttest, quasi-experimental design, suggest that *Choices* was effective in bringing about more gender equitable attitudes and behaviors among boys and girls. Finally, IRH developed the *CycleSmart™ Kit*, an approach to puberty education consisting of a set of CycleBeads, a calendar, a weekly diary, reusable/washable sanitary napkins, and a country-specific CycleSmart brochure. The brochure includes topics such as the menstrual cycle, puberty-related changes, risk of pregnancy and gender norms. Evaluation results suggest that the CycleSmart Kit helped girls better understand changes occurring during their menstrual cycle; allowed girls to easily track their menstrual cycles and appropriately plan for their next menstruation; helped facilitate important puberty discussions; and was viewed as culturally acceptable by parents.

Theme 4: It is critical to address gender-related issues in the design, monitoring and evaluation of FAM interventions.

A common theme across FAM research was the relevance of gender to solution design, implementation and M&E. For example, formative research to guide design of a voice-activated iteration of CycleTel revealed that gender inequities related to mobile phone use and ownership suggested that this would not be a feasible intervention and the decision was made not to continue its development. The effectiveness of strategies for increasing awareness of FAM were gender-specific, with women receiving information through health centers and men representing a disproportionate share of those seeking information online or through retail outlets. For example, in the study assessing the feasibility and effectiveness of magazine tear-outs in India, Facebook ads generated 21,969 clicks among males and 3,139 among females. Gender-equitable adaptations of social diffusion approaches increased involvement of men in different roles in FP efforts – not only as partners in FP use but as promoters and peers in their own right – and in the process transform community norms regarding men’s role in FP.

SDM and TDM users across all studies reported an enhanced sense of control of their fertility and increased partner engagement in FP use. In the study of community-based provision of the TwoDay Method in Guatemala and Rwanda, women reported that they were able to talk to their husbands about their fertile days and that their husbands reminded them to check and record secretions. Men in both countries reported greater understanding of their wives’ menstrual cycle and ability to achieve their fertility desires. Data from interviews with Peruvian and Guatemalan women before and after adopting SDM were analyzed to explore the relationship between SDM use and women’s empowerment (e.g. DHS questions on decision making, control over decision-making). Results in Peru did not show a significant relationship between SDM introduction in the community and women’s empowerment. However, India results suggest clear and consistent improvement in women’s empowerment in endline areas (compared to smaller or no improvement in control areas). In Guatemala, the extent of sex communication within the couple was consistently related to women’s ability to decide when to have or refuse sex, but inconsistently related to women’s decision making in the household. Comparing baseline to endline results, we found that SDM use was correlated with women’s empowerment.

FAM Research Studies: Systems-based approaches to introduction of Standard Days Method, Lactational Amenorrhea Method and TwoDay Method

A. Standard Days Method (SDM)

Standard Days Method in the Philippines: A Non-Strategic Approach to Scale-up of a Family Planning Innovation

Location: Philippines

Time period: 2008-2009

Partners: IRH/Philippines

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In the Philippines, increases in FP use have been disappointing despite considerable investment. After some years of intermittent support for SDM programming in the Philippines, IRH conducted an assessment of SDM scale-up in order to: 1) determine availability of SDM; 2) identify lessons learned and opportunities to inform strategies for further expansion; 3) inform IRH and other interested stakeholders on potential future programming in the Philippines, and 4) provide insight/information on scale-up activities for FAM focus countries. IRH used diffusion of innovations theory to guide investigation of scale-up and interpretation of findings. Data was collected through in-depth stakeholder interviews, focus group discussions, health facility assessments and health provider and community health worker interviews.

Key findings include:

- Providers in the Philippines have the interest and capacity to provide good quality SDM counseling; and the overall environment is favorable to SDM. Most providers and community health workers provide FP services, and include SDM.
- Primary barriers to services included limited availability of CycleBeads, gaps in IEC materials and improvements in addressing couple communication. Sectors of the Catholic Church opposed to SDM might also be barriers to scale-up.
- Integration of SDM into FP services seems feasible given client demand and availability and interest of community workers (barangay workers) in reaching potential SDM clients.

A well-defined scaling-up strategy could build support for SDM within the politically-charged context of family planning, decentralization, and USAID transfer of contraceptive procurement to the government. This study identified potential next steps to scaling up SDM in the Philippines, including generating support from the church; expanding strategies to address negative, politicized views of SDM; generating resources to upgrade technical capabilities; expanding and maintaining a network of community-based groups and FP/RH organizational partners to expand access and availability of SDM/CycleBeads; conducting FAM orientations for public and private sector leaders; and working with partners on a commodity distribution system to ensure accessibility of CycleBeads. In the future, a scale-up strategy that includes advocacy,

CycleBeads availability, and direct-to-consumer approaches could address barriers to SDM integration and increase demand for the method.

Evaluation of an Approach to Transition Postpartum Women to SDM Use

Location: Rwanda

Time period: 2011-2012

Partners: Rwanda MOH, Smart Consultancy Ltd., Rwanda

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Because SDM relies on a woman having regular menstrual cycles, postpartum women are not eligible to use the method until their regular cycles resume. IRH developed a set of guidelines designed to help postpartum women avoid pregnancy until they are eligible to use SDM. The study was designed to evaluate what happens when these postpartum guidelines are integrated into routine FP services. This study, conducted in 31 health facilities in Rwanda, evaluated an intervention in which service providers trained in offering SDM then received training to offer postpartum guidelines to clients as part of their SDM services. The study focused on the following research questions:

- Can providers correctly offer SDM including the postpartum guidelines?
- How acceptable are the postpartum guidelines to providers?
- What is the demand for the postpartum guidelines (i.e., how many women who are interested in SDM are not yet eligible to use it because they are postpartum)?
- Can women use the postpartum guidelines correctly?
- How acceptable are the postpartum guidelines to users and their partners?
- What is the proportion of women using the postpartum guidelines who transition to SDM?

Three methods were used to evaluate the effectiveness and feasibility of the guidelines: 1) application of the Knowledge Improvement Tool (KIT) to measure provider competency; 2) focus groups with 27 providers to assess their perception of the guidelines; and 3) interviews with 45 women who started using the postpartum guidelines during the study period to determine correct use and satisfaction; and 4) service statistics to establish demand for the postpartum guidelines.

KIT responses show good provider knowledge of SDM, CycleBeads, and the postpartum guidelines. Focus groups with providers showed that most providers found teaching the postpartum guidelines to clients easy, and they felt confident doing so. Overall 218 clients started using the postpartum guidelines during a four-month recruitment period. Service statistics show that more than half were counseled during child vaccination. At the end of the 11-month study period, 79 postpartum guidelines users (36.2%) transitioned to SDM, while 105 (48.2%) transitioned to other FP methods. Only eight women became pregnant during their seven-month follow-up period, and 26 women (11.9%) stopped using the postpartum guidelines without transitioning to another method, or dropped out of the study.

Some 45 postpartum guidelines users were interviewed two months after they started using the guidelines, and again five months later. In general, the study found that women can use the card correctly when they

get appropriate instruction. Most clients (97.8%) found the card easy to use, and easy for their partner to understand, and a 100% of interviewed clients said they would recommend it to others.

Results suggest that the postpartum guidelines are an effective and acceptable option for postpartum women to use until they are eligible to start using the SDM. When feasible, the postpartum guidelines should be added to SDM services.

Engaging community women and men in 'Each One Invites Three' to increase family planning use: Evaluation of a gendered social diffusion campaign in Rwanda

Location: Rwanda

Time period: 2011-2012

Partners: IRH/Rwanda

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Although knowledge of family planning is no longer a barrier to using contraceptives and the use of modern contraceptive methods has increased substantially in recent years in Rwanda, unmet need remains high at 19 % in 2010. Social diffusion can play an important role in spreading health information and ideas, with trusted individuals diffusing correct and relevant information through their social networks in order to break the social silence surrounding FP. An earlier, successful, women-centered campaign in Madagascar was adapted to the Rwandan context in 2011/2012. Male and female community health workers and community association members favorable to FP distributed information to non-FP using clients and friends. The EOI3 campaign hypothesized that distribution of invitation cards by satisfied FP users to their friends would create 'permission' to discuss FP issues, shifting from knowledge-centered discussions to attitudes- and satisfaction-centered discussions, which would increase FP awareness and motivation to seek services, ultimately increasing method uptake. We posited also that working with and through women's and men's associations would address gendered access to service and information and increase utilization. Data was collected through service statistics of 23 health centers in target districts, post-campaign interviews with 11 providers and 110 new FP users, and focus group discussions with association members.

Key findings included:

- Results showed a significant increase (60.5%) in number of new FP users in the targeted districts during the campaign compared to six months prior, in contrast to the control districts, which experienced a significant decrease (14.5%).
- The profile of new users who sought services: were primarily between the ages of 20 and 24 (mean age 29.4), 77.9% had four or fewer children, only 4.1% percent had more than primary school education
- The campaign appeared to motivate those who have never used FP before: 76.8% of new users reported not having previously used FP.

- SDM use increased significantly in all intervention districts with an overall increase of 52.1%.
- Men and men's associations were energized to be involved in FP efforts with their peers.
- Community perceptions of men's roles in FP became more open and accepting.
- Health care providers and community health agents reported that those coming for FP with invitation cards were clearer regarding their method choice and FP benefits than clients who had not been reached by the campaign.

The findings from the EOI3 campaign, based on social diffusion theory and its contextualized application in Rwanda, suggest the potential of social diffusion strategies to significantly reduce social barriers relating to FP uptake and significantly increase FP uptake. Gender-equitable adaptations of social diffusion approaches can increase involvement of men in different roles in FP efforts – not only as partners in FP use but as promoters and peers in their own right – and in the process transform community norms regarding men's role in FP.

Using Most Significant Change Methodology to Evaluate Impact of a Health Innovation in Four Countries

Location: Guatemala, India, Mali, Rwanda

Time period: 2010-2012

Partners: Various, including MOHs, INGOs and NGOs in the four countries

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In a complex systems process, such as scale up of a new method in national FP programs, M&E efforts typically focus on measuring the availability of the new method in services and, sometimes, the extent of method integration into norms, reporting, training, and other health systems elements. However, multi-year and multi-organization programs that focus on large-scale systems changes and have a values dimension (e.g. reproductive rights and equity in access), need additional, possibly non-traditional, evaluation components. IRH chose to use a participatory, qualitative technique – Most Significant Change – as one of its scale-up data sources. The Most Significant Change technique is a form of participatory M&E that involves the collection of stories of significant change, systematic interpretation of the stories and selection of the stories showing the most significant changes by a group of stakeholders. Most Significant Change can capture outcomes not detected by quantitative monitoring through participant reflection on personal and/or professional changes in their lives. Most Significant Change implementation was carried out by collecting stories from users, service providers, and program managers in public and private sector FP programs involved in the FAM integration and scale-up.

Implementation of the Most Significant Change technique in four of the five FAM Project countries (DRC is not represented) served as a mechanism to explore the personal impact SDM and LAM integration had in the communities and programs where the methods were introduced. Most Significant Change was implemented by 12 organizations and institutions and resulted in 155 significant change stories. The most significant contributions of FAM integration identified by program managers was making them feel their organization was being both responsive to clients and respecting their right to informed choice by including natural methods in the FP options they offer. One of the key themes of significance seen across countries is the increased knowledge of FP brought on by the inclusion of SDM and LAM training for service

providers. Providers appreciated the opportunity to learn more about the menstrual cycle as it helped them to explain FP methods to their clients. Providers were also able to connect with religious institutions and offer natural options for clients discouraged from using certain methods due to religious beliefs. For SDM users the most significant change experienced was their husband or partner's involvement in SDM use. Women spoke about increased communication regarding SDM use with their partner and some women mentioned their husband's help in using the SDM. Another important factor for women was that SDM has no side effects.

Overall, participating organizations considered participating in MSC a positive experience. Some organizations were grateful to learn a new technique for M&E and planned to apply it to other programs. Although to many, the methodology seemed 'awkward' at first, program managers and providers valued the ability to measure significance in the lives of the people they serve. FP users appreciated the opportunity to share their thoughts on aspects of FP use that have the greatest impact on them. The stories provided added value to already comprehensive evaluation plans to measure the integration and scale-up of SDM in focus countries because they assessed aspects of scale-up that other instruments could not. Additionally, the design of Most Significant Change adheres to the principles of the ExpandNet model of scale-up, which insists that the core values for different audiences not be lost during expansion but rather evaluated and assessed throughout the process. In the case of SDM integration, core values include reproductive rights, women's empowerment and male involvement, which Most Significant Change stories confirmed as results of SDM integration.

B. Lactational Amenorrhea Method (LAM)

Assessment of the use of a LAM User Card to Improve Recording of this Family Planning Method in Ministry of Health Clinics in Sololá, Guatemala

Location: Guatemala

Time period: 2011-2012

Partners: Guatemala MOH and IRH/Guatemala

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In Guatemala, despite providers' familiarity with LAM and its inclusion in policies and norms, few health centers inform clients about LAM or offer it to women. Additionally, there is confusion among providers and users regarding the criteria for LAM; many users and providers equate exclusive breastfeeding with LAM use. This research examines the development, introduction and use of a LAM user card for Guatemala designed to: 1) improve reporting of users, 2) increase provider and user knowledge of LAM criteria and 3) facilitate the transition to other FP methods.

Through provider and stakeholder interviews and a review of monthly service statistics, the study sought to determine if the LAM user card makes a difference in provider and user knowledge of LAM, including when to transition to another FP method, as well as correct recording of LAM users. A quasi-experimental design compared LAM counseling with the LAM user card (experimental group) to counseling using only

the MOH LAM brochure (control group). Key findings include:

- Most stakeholders value LAM as a FP method, but reported that provider bias against LAM was a major barrier. Stakeholders considered the LAM user card a practical and feasible approach for improving LAM recording and knowledge among users and providers, however, concerns remain regarding reproduction costs and government commitment to providing the cards.
- At endline knowledge of the three LAM criteria was high for both control and experimental facilities, but slightly higher in the control facility. In both the experimental and control facilities, most providers stated at endline that they had offered LAM in the previous three months. Providers in the control group did slightly better at correctly identifying all three instances when LAM users should transition to another method of FP. At endline the percentage of providers who registered a LAM user was 70% or higher in both the experimental and control group.
- Service statistics showed a slight increase in LAM users in the experimental area at the start of the study period, however, in the middle months there is a significant increase in LAM users in the control group compared to baseline.

A number of reasons could explain these results, including weaknesses in the Guatemalan health system (i.e. outdated reporting forms, frequent staff rotation, unsystematic training procedures, commodity stock-outs, etc.), all mentioned by stakeholders as problems faced mostly in the experimental area during the study. There were several lessons learned from carrying out the study:

- In order to test and integrate any FP innovation, it is essential to have effective communication between the central-, department- and district- level MOH and providers.
- Local district leadership plays a strong role in the quality of services and functioning of a system such as this, which can influence the results of studies.
- While LAM knowledge among providers is already high, tools such as the LAM user card can improve counseling and help users remember method criteria.
- It is difficult and possibly not a priority to test the acceptability and integration of a new material when stock outs exist for current FP materials and even commodities.

C. TwoDay Method

TwoDay Method Market Research: IRH Experience, Evidence and Recommendations and Interviews with Stakeholders, Donors, and Possible Future Collaborators

Location: USA
Time period: 2009-2010
Partners: Kimberly Aumack-Yee (Consultant)
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In order to complete development and testing of the TwoDay Method and to design a plan to generate and respond to programmatic demand for the method, information was needed on IRH experience, evidence and recommendations for future TwoDay Method activities. Information was also needed on international service delivery organizations, donors and individuals who may be interested in incorporating the TwoDay Method into their work, and the types of evidence, tools, and materials they would require. A review of TwoDay Method-related peer-reviewed journal articles, project-specific reports, and implementation materials was conducted. Interviews with 12 IRH staff, former staff, and consultants with direct experience in TwoDay Method research, client education, training, and service delivery were also conducted. Key findings included the following:

- TwoDay Method had great potential, but information was too limited to assess demand for it.
- Barriers to TwoDay Method inclusion into programs included lack of awareness of the method, a funding focus on long-acting contraception, limited resources, biases against the method on the part of providers and policy makers, and concerns about how lack of client or partner motivation may affect method efficacy.
- Many stakeholders described the potential advantages of a non-commodity method (particularly in areas with limited resources) and suggested that TwoDay Method could help address unmet need for FP, expand choice, and empower women and girls.
- Perceived challenges included concerns about partner involvement in method use, cultural taboos regarding touching the genital region, confusion about secretions, and funding constraints (in terms of the need for quality training for client education).

Stakeholders identified numerous approaches and organizations appropriate for integrating TwoDay Method, including youth-based programs, FBOs, human rights initiatives, literacy programs, and microenterprise groups, in addition to traditional RH/FP programs. Recommendations included suggestions to simplify the method and training, increased advocacy for TwoDay Method, integration of TwoDay Method into existing programs, and collaboration with influential organizations.

Feasibility Knowledge, Attitudes and Behaviors of TwoDay Method Users in Rwanda

Location: Rwanda

Time period: 2007-2009

Partners: Action Familiale Rwandaise (AFR)

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IRH developed and tested the TwoDay Method in response to the concern that the Billings Ovulation Method (BOM) was too complex and time-consuming for broad application, particularly in developing countries. Both the TwoDay Method and BOM use cervical secretions – which fluctuate during the menstrual cycle under the influence of hormones and are observable by women themselves – as the basis for determining when a woman is fertile and when she is not. BOM has been spread widely, primarily through FBOs related to the Catholic Church, and has many adherents around the world, but is often difficult to implement in developing country contexts. Before launching an effort to engage programs in

offering the TwoDay Method, it is important to understand how BOM providers and users will adapt to the TwoDay Method. In collaboration with international and in-country partners, IRH has completed a pilot introduction of the TwoDay Method into the health service delivery systems of the faith-based organization, Action Familiale Rwandaise (AFR), to provide evidence to refine and adapt training methodologies and provider and client tools, and provide information to guide TwoDay Method expansion. This descriptive study included in-depth interviews with the 32 women in Rwanda and their partners who adopted the TwoDay Method.

TwoDay Method appeared to be a positive addition to the basket of FAM methods offered by organizations that already offer NFP, with both providers and users stating that they liked the method. While there was some confusion between the TwoDay Method and other NFP methods, it was limited and could be addressed through appropriate training of the providers. While TwoDay Method could be offered by public health and FP services, results suggested that programs that already offer NFP methods, such as church- and other FBOs, should not be excluded from offering the method on the basis of possible provider or client confusion. This is an important finding as IRH prepares to scale up the TwoDay Method.

Community-based Provision of TwoDay Method

Location: DRC, Guatemala

Time period: 2012

Partners: Action Santé et Développement, Projet Communautaire pour le Développement Integral (DRC) ; Asociación Berhorst Partners for Development (Guatemala)
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IRH undertook this research to evaluate the feasibility, acceptability, and effectiveness of offering the method to low-literacy populations through community-based service provision outside of the structured health system.

Research questions addressed by the study included:

- What is women's ability to check their secretions daily, keep track of them, and determine their risk of pregnancy on a given day, based on observations (e.g. presence or absence of sections)?
- What tool or memory aid (if any) does a woman need to begin using and continue using the TwoDay Method correctly and to facilitate partner communication?
- What tools (if any) do community workers need to explain the TwoDay Method to new users?

Research was conducted in several phases to develop strategies and materials for offering the method to the target population. Formative research was undertaken in collaboration with local organizations to ensure all approaches were acceptable within the context of the local norms and values of each study site. Findings from the formative research were used to develop a package of materials, including a standard procedure to help women check their secretions, a simplified tracking tool, and accompanying low-literacy teaching materials, including training for community-based workers not skilled in offering health counseling services. Clients were offered a choice among three different tools for keeping track of

secretions and the fertile days, which allowed for in-use testing of the approach that women in the community considered to be the easiest or most attractive. Finally, the package of materials was tested using Trials of Improved Practices (TIPs), a research methodology that combines anthropology and commercial marketing research techniques to determine obstacles and motivating factors for trying a new health behavior or practice.

Results showed that participants found TwoDay Method easy and practical to use. All women in DRC and several in Guatemala planned to continue using the method after the study ended, and nearly all said they would recommend it to a friend. Despite the development and introduction of a simple, paper-free mnemonic device to help women check secretions and determine the fertile period, participants showed a strong preference for daily, paper-based memory aids because they were easy to use, had clear instructions and helped women to remember to check secretions every day. Further, these memory aids facilitated improved couple communication during use of the method. All women reported that they were able to communicate fertile days to their husbands, and data show that husbands not only accepted the method, but also helped their wives remember to check and record secretions. Men in both countries felt empowered by the improved understanding of their wives menstrual cycle and ability to achieve the couple's fertility desires. Using TwoDay Method also helped women distinguish unhealthy secretions from healthy secretions that indicate fertility, which in turn enabled them to avoid potentially harmful vaginal drying practices.

The study demonstrated that community-based organizations without health-focused activities were able to successfully integrate TwoDay Method provision into their portfolio of existing activities. Community workers with various levels of health knowledge and counseling skills learned and provided the method to participants, who expressed a preference for counseling from community workers rather than clinic-based health service providers. Supportive supervision for community workers was vital to ensuring quality method provision, however, and a minimum of two follow-up sessions with clients were necessary to achieve correct and consistent method use. Linkages with the formal health sector were key as well, to facilitate referrals for access to condoms or other methods desired by clients and for sexually transmitted infection (STI) testing.

FAM Research Reports: Expanding access to FAM by reaching under-served populations and developing direct-to-consumer approaches

The Introduction of SDM User Card: A Needs Assessment to Determine the Feasibility and Potential for Introduction in Latin America and sub-Saharan Africa

Location: Mali, Rwanda, Guatemala, DRC, India, Philippines, Senegal, Malawi, Kenya, Peru, USA
Time period: 2009

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To facilitate teaching men and women about SDM, IRH developed a string of color-coded beads – CycleBeads – as a visual aid to track fertile days of the menstrual cycle. However, because cost, access and/or availability could be problematic in resource-poor and/or post-conflict settings, an SDM user card with a printed image of CycleBeads was developed, pretested and validated as an alternative tool. The primary objectives of this needs assessment were: (1) assess whether there are some places where it would be strategic to introduce the SDM user card as an alternative to CycleBeads; (2) select 1-2 settings and programs that are most appropriate for the introduction of the SDM user card; and (3) identify research questions and evidence needed to offer a SDM user card as a viable alternative to the CycleBeads. In 2009, IRH researchers conducted 16 telephone and face-to-face semi-structured interviews with IRH country representatives and key stakeholders/partners in Mali, Rwanda, Guatemala, DRC, India and Philippines, as well as 17 interviews with key stakeholders/partners with a potential interest in a SDM user card in Senegal, Malawi, Kenya, Peru and Washington DC. Results revealed that:

- Most participants consider the introduction of a SDM user card feasible among semi-literate to literate populations in areas that have not had prior exposure to the CycleBeads.
- Introduction may be easier in countries where couples and women are familiar with a card-based system (health cards).
- A SDM user card could be provided to clinics as a back-up to CycleBeads in case of stock-outs. Alternatively, it could be offered to a particular segment of the population – at low cost/no cost, while selling CycleBeads to other segments that could afford to purchase them.

Countries where gains have been made in wide availability of the CycleBeads were not seen as appropriate for introduction. Most interviewees agreed that a SDM user card should be introduced in areas without exposure to CycleBeads, with low FP use, and/or which have difficulty procuring FP commodities. Most participants felt that introduction of a SDM user card would contribute to broader access to SDM, once the target population was determined, logistics agreed upon and advocacy with stakeholders, providers and communities undertaken. Most felt that evidence should be generated on the cost, acceptability, understanding and uptake of the user card, although suggested research designs varied. Results from these interviews will be used to determine the potential role of a SDM user card and guide decision making on whether to proceed with pilot introduction of a SDM user card in selected sites. Our findings will provide pertinent information as to next steps in generating and providing evidence for use and scale-up of SDM user card in selected countries.

Offering the Standard Days Method (SDM) in small shops ('boutiques') in rural Mali

Location: Mali

Time period: 2009-2011

Partners: PSI, Malian MOH

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In Mali, high fertility rates are coupled with low contraceptive prevalence. Poor access to and lack of availability of health services and health providers can be a deterrent to utilizing FP/RH services. In rural areas of Mali, where health facilities may be distant from potential clients, small stores or “boutiques” that sell food and household supplies also sell contraceptives. Stand-alone contraceptive products sold at boutiques can eliminate the need for counseling by a health provider. Boutiques are more numerous than pharmacies and provide greater access to contraceptive commodities outside the clinic setting. With this study, IRH and PSI examined the feasibility of providing CycleBeads through such boutiques. In early phases, the team pilot tested and revised the instructional insert that accompanies CycleBeads, promoted CycleBeads with the insert as a direct-to-consumer FP product, and then sold the product through boutiques. Interviewers recruited 50 adults (25 men of any age, and 25 women, 15-49 years of age) randomly from local markets in Koulikoro and Segou districts for the first round of insert testing. The tested insert had one side with illustrations and simple phrases describing how to use CycleBeads, while the other side had illustrations only.

Based on results of this testing, the insert was revised, adapted, and re-tested (two additional rounds) with another group of 100 individuals, all of whom had at least primary level of education, in the same two areas of Mali. The pictorial side of the insert was eliminated, as participants better understood the messages when the images were accompanied by brief explanations (images + text side). Specifically, 90% of men and all women understood that SDM is for women with menstrual periods that come about once a month. About three-fourths of women and 62% of men understood that couples who communicate with each other well and accept to abstain or use a condom on fertile days can use the method. Comprehension of when to see a health provider improved for women over the four rounds of testing, yet remained at the same or lower level for men.

Although the original intent of this study was to develop a pictorial-based insert (with minimal to no wording) for the general Malian population, results indicate this is not an effective approach. These findings have implications for other countries, as the instructional insert must have images accompanied by descriptive wording, in order for users to understand on their own how to use CycleBeads/SDM. In Mali, the inserts that accompany CycleBeads will be replaced with the revised inserts developed in this study. IRH is working with PSI and the MOH to accomplish this task.

Direct-to-Consumer Distribution of a Paper-Based Version of Standard Days Method® in Benin

Location: Benin

Time period: 2009-2011

Partners: C-Change (FHI360)

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In 2009 IRH collaborated with FHI360’s C-Change Project to test the effectiveness of a direct-to-consumer approach for delivering a paper tool to use SDM in urban and peri-urban neighborhoods of Cotonou, Benin. Phase I focused on the development of an initial prototype of the paper SDM tool to be modified and used in the following phases. Phase II consisted of a small-scale field test of correct and successful use of two paper SDM prototypes. Phase III assessed the uptake of the final paper SDM tool in a community based field test.

Key questions concerned the acceptability and correct use of the paper SDM tool, the most effective way to promote, market, and disseminate the paper version, and whether it contributed to the uptake of SDM. The paper SDM tool was successfully distributed through kiosks and salons. In total 1761 paper SDM were distributed through 24 salons and 14 kiosks in Ahogbohouè and Gbégamey over the month test period. Salons averaged a slightly higher distribution than kiosks.

Key findings indicated that the paper SDM tool and SDM were well accepted by providers and potential users who participated in focus group discussions, in depth interviews, and intercept interviews. Positive attributes included that the method has no side effects, is natural and simple, and has no cost. Respondents understood the images, messages instructions and diagrams on the paper SDM. Women were interested in using the method to understand their menstrual cycle better and/or to prevent an unplanned pregnancy. Some women shared that their partners liked the paper SDM tool, helped them to understand it and reminded them to use it. Religious and partner disapproval were the most common reasons for not using the method.

In order to determine if users were able to correctly and successfully use the tool without initial counseling, women were recruited to track their cycles only, following the instructions for the paper SDM tool. Most women were able to read the paper SDM tool with few or no errors. About half of the respondents said they received help to understand the tool, mostly from partners.

Uptake of the paper SDM tool was assessed with intercept interviews with women who took a copy of the paper SDM tool with them from the kiosk or salon. Two-thirds of intercept interview respondents said they would follow up with their providers. Nearly two-thirds said they would use the paper SDM tool in the future, and half also said they would use CycleBeads (a set of color-coded beads that help a woman to track her menstrual cycle and know if she is on a fertile day or not). Data from service delivery points confirmed that the paper SDM tool facilitates uptake of CycleBeads showing an increase in requests for FP information during the intervention period, and a decline one month after the activity.

The paper SDM can be used as a promotional tool to increase awareness of SDM, fertility awareness and FP in general. The low cost of production of this tool facilitates wide dissemination beyond traditional service delivery points. The paper SDM tool was widely disseminated using direct-to-consumer distribution. Findings confirm that SDM and the paper tool are accepted by providers and potential users. Most women with some level of literacy can understand and use the paper SDM on their own, without provider assistance.

Direct-to-Consumer Outreach of CycleBeads through Magazine Tear Outs

Location: India

Time period: March 2011 – May 2013

Partners: GFK MODE, HLL Lifecare Ltd., Street Life Advertising

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Under the FAM Project, IRH was mandated to explore various channels—including the public health system, social marketing, and private sector—through which FAM could be offered to increase FP use. In India, the private sector is the primary source of health care. With regards to FP, the private sector serves more than 90% of condom and injection users and over 60% of pill and intrauterine device (IUD) users. Under the FAM Project, IRH took steps to partner with the private sector to manufacture and distribute CycleBeads. For example, HLL Lifecare Ltd. is the largest contraceptive manufacturer in India and a quasi-governmental enterprise, and is also India's only licensed manufacturer and distributor of the SDM tool CycleBeads. Next, IRH sought to understand how to expand access to and demand for SDM through direct-to-consumer approaches.

Leveraging the internet and mass media, IRH designed a study that explored the feasibility of offering CycleBeads directly to consumers through the promotion of CycleBeads in full-page advertisements in popular magazines. The magazines featured a magazine tear-out version of CycleBeads that could be used directly by a woman to screen herself for SDM eligibility and identify her fertile days. The magazine tear-out gives the user an opportunity to try CycleBeads for one cycle before purchasing the product online. As part of magazine tear-out study, IRH and HLL Lifecare offered CycleBeads online for Rs. 150 (roughly \$2.50 USD) while using magazines, digital media, and social networking as promotional channels. To position the product in the commercial market, HLL branded the tool as Makesure® CycleBeads, using special packaging to differentiate it from the standard CycleBeads offered through government programs.

Project implementation consisted of several components: (1) conceptualizing the ad concepts (ad concepts); (2) pretesting the creative strategy; (3) creating the magazine ad and supporting digital platforms; (4) printing and releasing the magazine ad; and (5) creating and launching the digital promotional campaign. The ads ran in popular magazines from December 2012-February 2013. Social media and digital advertising continued through May 2013.

GfK Mode, a research organization, was hired to evaluate the effect of the ads on generating interest for SDM. They conducted 234 intercept interviews with women ages 22-35 years old in upscale retail places in Delhi. Of the 79% of respondents who could recall seeing an ad for contraception in a recent magazine, 7% could spontaneously recall "Makesure" as the product name shown in the advertisement. None of the respondents used the tear-out, but about 4 of the respondents who claimed to have seen the advertisement spoke about the product with a family member, husband, or friend, suggesting that the ad was able to generate some level of interest among respondents.

Google Analytics showed 32,000 page views of the www.MakesureCycleBeads.in website within six months. Most visits to the website came from Delhi, Bangalore, Pune, Kolkota, and Mumbai. After the homepage, the most popular page was 'How to Use Makesure CycleBeads'. Facebook ads generated 25,108 clicks (21,969 males, 3,139 females), and Google ads yielded 2,528 clicks. The digital ad campaign results, which were monitored and adapted continuously, revealed important strategies for future use, such as which slogan and pictures are most effective. From December 2012 to March 2013, there were 16 calls to the helpline. 10 calls were from men. Most callers wanted to know more about the product, how it is purchased, the price, and how it is delivered. Did promoting Makesure CycleBeads through magazines and an online campaign lead to online sales of

the product? During the study, 30 pieces of Makesure CycleBeads were sold. Somewhat surprisingly, the majority of purchases were made by males aged 27-35 who were married or engaged. Some made the purchase based on the magazine ad, but the majority who purchased did so after being exposed to the product through Facebook and Google ads, showing that a digital campaign has high potential to increase online sales.

These findings and the overall experiences suggest that proper promotion and support of the product can lead to significant sales. The magazine tear-out study further confirms that offering CycleBeads directly to consumers, especially via online channels, can be a feasible way of making SDM sustainable in India.

Using SDM via SMS: Proof-of-Concept testing of CycleTel

Location: Lucknow, India

Time period: May - November 2011

Partners: FrontlineSMS, GFK Mode

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Georgetown University's Institute for Reproductive Health (IRH) has developed CycleTel, a SMS-based application that enables couples to use the SDM using their mobile phone. CycleTel represents the first application to actually deliver a FP method to individuals and couples via mobile phones.

The objectives of the proof-of-concept study were to determine the acceptability and feasibility of supporting SDM use with the CycleTel mobile phone service. The study sought to understand mobile phone use patterns; the appropriate content, frequency and timing of the messages; whether women would like their husbands to participate in sending or receiving text messages; and how to reach potential users. The results of this testing informed the next stages of developing the service, which include technology development and pilot testing.

This study was conducted in the city of Lucknow, in the state of Uttar Pradesh, India. India was selected as a location for the study as SDM has been shown to be an attractive method, and studies have shown that Indians can use it correctly. We are targeting urban areas for CycleTel since that is where mobile phone use is most prevalent.

The study was conducted in three phases, with the structure and results of each phase as follows:

- **Phase 1—Focus Group Discussions:** We held a total of seven focus group discussions—four with women, two with men, and one with couples, with approximately 54 participants total—which yielded valuable findings about potential interest in CycleTel and feedback on the service's features. We learned that potential demand for the service existed, as many men and women wished to use a NFP method but did not have correct knowledge of their fertile days. Second, messages should be discreet and non-technical. For example, all participants strongly preferred the message, "*Unsafe day,*" to the more literal, "*You can get pregnant today.*" We also learned that "Hinglish"—Hindi words spelled in the Roman alphabet—was the preferred language for the messages; that approximately half of the

respondents felt that men should also have the opportunity to receive messages; and that people were willing to pay for a monthly CycleTel subscription.

- **Phase 2—Cognitive Interviews:** The cognitive interviews were structured to verify message comprehension and finalize the message content. This phase resulted in significant reworking of the messages to make them easier to understand by simplifying the language, removing unnecessary words, and substituting commonly used, simple English words for Hindi words and phrases that were more complicated and less familiar to users.
- **Phase 3—Manual Testing:** The last phase tested the service with actual users. Since an automated system had not yet been developed for CycleTel (it was to be developed based on the results of this research), IRH hired and trained an individual CycleTel “operator”, who sent the CycleTel messages to participants, and tracked them, using FrontlineSMS software on a laptop. To keep it manageable, we limited the number of manual testing participants to 30 women. The manual testing phase confirmed that CycleTel could be used successfully. Participants were very satisfied with the method, felt that it improved their communication with their partner, and would have liked to continue using it if the service was available. Participants were willing to pay up to 50 rupees per month to subscribe to such a service. Although 32 women were interviewed upon admission, only 26 women ultimately started using CycleTel, and 19 completed two cycles. Some reasons for dropping out include lack of motivation to prevent pregnancy, and potential difficulty comprehending and sending text messages due to the lower educational level of some of the participants.

Based on this study’s results, IRH confirmed that CycleTel holds great promise as a mHealth intervention with potentially large impact and recommended manual testing with additional users in Delhi to ensure appropriateness of the service to a slightly more educated group of users in a larger city.

Using Standard Days Method® via Text Messaging: CycleTel™ Automated Testing

Location: New Delhi (Delhi-NCR), India

Time period: June 2011 – January 2012

Partners: AC Nielsen, Indian Society of Healthcare Professionals (ISHP), ThoughtWorks

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IRH developed CycleTel™, a mHealth innovation that uses SMS to enable couples to use SDM using their mobile phones. To develop the service, IRH followed a rigorous, step-wise product development process, the first components of which included proof-of-concept testing, technology development, and automated testing.

Building on earlier CycleTel research, the purpose of the automated testing phase was to: 1) ensure that the automated technology functioned properly with a higher volume of users; 2) evaluate user experiences with the service and integrate user feedback before scaling the technology; 3) test the feasibility of integrating the service with a fully-functioning FP helpline; and 4) develop processes to handle real-time data analysis and system monitoring. The results of the automated testing were intended to inform the next

stages of the product development cycle, which include business planning and market validation, and ultimately launching the service in India.

This study was conducted in the greater New Delhi area, referred to as Delhi-NCR, in India. India was selected as a location for the study as SDM has been shown to be an attractive method, and studies have shown that Indians can use it correctly. IRH is targeting urban areas for CycleTel since that is where mobile phone use is most prevalent.

The study recruited 715 women to use CycleTel as a FP method for two menstrual cycles of use. All participants were screened and interviewed at admission, and also interviewed again at exit. 653 women completed the exit interview. Additionally, a sample of women (n=197) was interviewed after one menstrual cycle of use to glean initial feedback. The husbands of participants were invited to participate in an exit interview, and yielded 131 interviews that captured husbands' perspectives about the service.

Similar to the proof-of-concept results, over 95% of users interviewed at exit (n=653) reported that they received messages at an appropriate time and in an appropriate quantity, indicating that the technology worked as designed. When asked what they liked most about CycleTel, more than 80% of users reported appreciating its ease-of-use and the timely reminders, which will help further define CycleTel's value proposition for potential consumers. About 230 calls were placed to the helpline by users to report issues with sending, receiving, and understanding messages. The majority of calls were received during user registration, and tapered off to less than 7 calls per week towards the end of the testing. The helpline counselors were able to resolve most queries with support from data provided through technology backend.

The automated testing afforded IRH the opportunity to identify technology issues and improve the daily functioning of the service, as well as to add or change features based on feedback from users and project administrators. For example, the CycleTel database now generates a user status report which is used for monitoring the service. Also, the date reset function was eliminated from the service since it created an unintended consequence for users.

Overall, the automated testing was successful in (1) validating that the technology generally worked as expected, (2) integrating a helpline into the service, and (3) determining processes for monitoring the service.

CycleTel™ Business Analysis

Location: New Delhi, India
Time period: January – February 2012
Partners: Boston Consulting Group, India
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In early 2012, IRH hired a business strategy consultancy firm in India, The Boston Consulting Group (BCG), to develop a viable business plan for how to commercialize and launch CycleTel in India, with the goal of making it financially sustainable within a three- to five-year timeframe. The plan includes an analysis of CycleTel's market potential, potential go-to-market strategies, and a financial model.

BCG divided the analysis into three content areas (in bold below), and relied on the following methodology:

- First, BCG defined the CycleTel **value proposition** and target market through using secondary research, analyzing the pilot data, and conducting interviews with a variety of stakeholders.
- Second, to identify the CycleTel **go-to-market model**, they used company expertise and industry knowledge to set assumptions and met with potential partners to explore the feasibility of the hypothesized model. Taking into consideration other perspectives, BCG presented to IRH different scenarios for how CycleTel could operate.
- Third, using a financial model and inputs from industry experts and partners, BCG developed a **business plan** that supports that CycleTel can become a viable self-sustaining social venture in 5 years assuming that certain conditions are met. They developed two scenarios—high achievement and moderate achievement cases—based on varying levels of donor funding secured to launch the initiative.

The business analysis summary is as follows:

1. CycleTel should target ~16 million young Indian women (20-34 years old) with high birth spacing needs, and independent access to mobile phones in 2 phases:
 - Phase 1 will target ~10 million women with >\$3K per annual household income;
 - Phase 2 will target remaining ~5.5 million bottom-of-the pyramid segment with a voice- based offering.
2. Given the value proposition, CycleTel needs to build a 500,000 to 1 million user base by 2017. This will ensure self-sustainability of the business model after reaching critical scale from subscription revenues.
3. Achieving this scale would require a substantive go-to-market effort, building on IRH capacity and mobilizing USD \$2.5 to 4.0 million in donor funding from multiple sources to drive awareness in the adoption phase. Initial discussions with potential partners indicate several willing partners for core delivery architecture as well as awareness building efforts.

The business analysis was a critical step in the development of CycleTel's scale-up and sustainability plan. The analysis found that CycleTel has the potential to be self-sustaining within a five-year period if certain conditions are met, including if IRH-CycleTel can attract anchor funding from donors and specific go-to-market partnerships to accelerate customer awareness and adoption. The analysis is instrumental in supporting conversations with, and formal proposals to, donors and partners who are interested in the innovation. The business analysis provides a blueprint for taking CycleTel to scale, but it must be noted that the business plan is based on assumptions. If one assumption is not met, the business plan will need to adapt to deal with the impact of that change. In the next phases of CycleTel's development cycle, IRH will work to test the business plan's assumptions and further hone the plan based on market validation.

Exploring Family Planning and Mobile Phone Use among Low-Literate Population in Peri-Urban Areas of Delhi, India

Location: 3 sites in India: Ashoknagar, Loni, and Dankaur

Time period: April – July 2013

Partners: The Maharashtra Association of Anthropological Sciences - Centre for Health Research and Development (MAAS-CHRD)

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After successfully testing the SMS-based version of CycleTel among literate women, IRH sought to explore what technology adaptations were needed to make it an appropriate innovation for low-literate women. In the first phase of testing, IRH discovered that a voice version of CycleTel was not easy for illiterate women to understand. In the second phase, IRH aimed to test the CycleTel concept among lower literacy women, with the goal of better understanding their understanding of FP and use of technology. The study's purpose was to collect information on: 1) the study population's general attitudes, values, and norms about family health that could affect acceptance and use of CycleTel; 2) how women and men with lower literacy levels access health information; 3) the general level of knowledge about the menstrual cycle, fertility, and FP; 4) where individuals seek information about these issues; 5) how women and men describe their mobile phone use; 6) if mobile phones are seen as an acceptable way to access health and/or FP information; and 7) how people react to simulated mobile phone messages about the SDM.

IRH worked with MAAS-CHRD, a research organization, and AWSAR-India, a community-based organization, to conduct this study in three sites—Ashoknagar, Loni (lower middle class population), and Dankaur (brick-kiln workers population) in the peri-urban areas of Delhi bordering Uttar Pradesh. The AWSAR-India staff recruited 27 married participants (18 women and 9 men), between the ages of 18-34 years old in the low literacy and basic literacy categories, to complete interviews. Participants had to own or have access to a mobile phone. Interviews were conducted in the local language (Hindi) and audio-recorded. After transcription and translation, interviews were processed using a qualitative data management program, MAXQDA.

The study revealed strong traditional beliefs and male control over household decisions, including those related to FP. In general, there was a lack of awareness and information about fertile days, conception, etc. Women reported tracking their menstrual cycles mainly for preventing conception and for personal hygiene. Use of sanitary pads was uncommon. Beliefs such as associating menstruation with being filthy still exist in some high-income households, and women are isolated during that period. Among their main information sources, women reported elder female relatives, such as sisters-in-laws, or lady doctors, while men reported discussion in peer groups or with work colleagues. Both men and women reported that they know about FP, particularly condoms, Copper-T and contraceptive pills; however there were some reservations regarding their use. Men generally owned mobile phones, while most women did not. While men were conversant with different functions on mobile devices, women were mostly restricted to the call function. The expenditure on phone call recharge was minimal (Rs. 10-50 in a week or fortnight) in many households. When asked about the concept of receiving mobile-based information on FP, many were favorable, but a few expressed reluctance. After the simulation, men expressed a preference for SMS to

avoid interruptions during work hours, while women preferred phone calls because they were not aware of SMS. The final decisions about FP and mobile phone use rested with men.

CycleTel and SDM were difficult concepts for the study population to understand. For this community, it is recommended that community-based organizations raise awareness for FP via one-on-one communication or group discussion. Although mobile phone use is common in the study areas, factors such as limited FP awareness, low literacy causing language barriers, low affordability, and limited access to mobile phones for women among a strong male-dominated community raise questions whether mobile phones are the best mode to reach this population at this point in time.

FAM Research Reports: Explore gender as a cross-cutting theme in FAM and test approaches to build a foundation of fertility awareness and gender equity among adolescents

Engaging Men in FAM and women's empowerment

Location: India, Peru, Guatemala

Time period: 2009-2010 reanalysis of data collected during AWARENESS study

Partners: Federico León, consultant, Peru

[Download full report](#)

Several studies were conducted during the AWARENESS Project, which ended in 2007, that included questions to respondents to measure couple communication and women's empowerment. The consultant was hired to analyze data from these studies to determine the effect of SDM use and couple communication on women's empowerment.

Two studies were included in the analysis. First, a study that followed SDM users for six months of use, after randomizing them into using CycleBeads or a paper card that serves the same purpose. Baseline and exit interviews with 602 women and 361 men who accepted SDM were focused on questions that would allow us to compare the two groups, but included also a series of questions about couple communication and women's empowerment. Second, a study in India and Peru to integrate SDM into FP services in a whole region. This study was a precursor to the FAM SDM scale-up project, designed to gauge what happens when the method is appropriately integrated into services in a larger geographical area than in introduction studies. Large baseline and endline surveys with women and men in intervention and control communities (combined $n > 10,500$) included a series of questions about women's empowerment. These surveys allowed us to measure change at the community level (so not just SDM users) of SDM introduction.

Women empowerment was measured using several scales as proxy. In the India and Peru study, these were: (a) an index for decision making in the household, (b) index of the right of the woman to refuse sex under certain circumstances, and (c) index of attitudes toward wife beating. These three scales range 0-5. In Guatemala, we used a decision-making index (range 0-4) and an index on attitudes toward the right to

refuse sex (range 5-15). In Guatemala (only) we constructed also a scale about couple communication regarding sex, which ranged 4-12, and consisted of answers two four questions about the topic.

Results in Peru did not show a significant relationship between SDM introduction in the community and women's empowerment. However, India results suggest clear and consistent improvement in women's empowerment in endline areas (compared to smaller or no improvement in control areas). The increase was evident in all three indices in women's interviews, and in two of the three indices for men. The changes were at the community level (regardless of SDM use), but bigger increases were noted for women who had heard of the SDM, and even bigger increases for SDM users.

In Guatemala we found that the extent of sex communication within the couple is consistently related to women's empowerment to decide when to have or refuse sex, but inconsistently related to women's empowerment regarding decision making in the household. Comparing baseline to endline results, we found that SDM use was correlated with women's empowerment.

My Changing Body: Puberty and Fertility Awareness for Young People, 2nd Edition: A Pilot Study in Guatemala and Rwanda

Location: Guatemala, Rwanda

Time period: 2010-2011

Partners: CRS/Rwanda, Caritas/Rwanda and APROFAM/Guatemala

[Download full report](#)

Early adolescence is a critical time in the life of a young person. In addition to the physical, cognitive and emotional changes that come just before and during puberty VYAs between ages 10-14 are acquiring information, developing attitudes and experimenting with behaviors that will affect their future health and well-being. The knowledge, attitudes and skills acquired during the ages of 10 to 14 set the stage for healthy sexual relationships and self-care practices that prevent unintended pregnancy and disease. Meanwhile, the challenges of parenting VYAs, especially in regards to SRH, and the influence of other community members on youth, are additional considerations that SRH programs must take into account. The challenge for VYA programming is to understand what information and skills are age-appropriate and necessary throughout the 10 to 14 year period.

Partnering with youth-serving organizations in both Guatemala and Rwanda, IRH implemented interactive sessions designed to teach girls and boys ages 10 to 14 about puberty, fertility, self-image, gender norms and roles, communication, protective and risk behaviors, and relationships in and outside the home. The material is drawn from *My Changing Body* (MCB), a training manual for youth, which IRH revised ([My Changing Body: Puberty and Fertility Awareness for Young People, 2nd Edition](#)). A corollary set of participatory exercises for parents improves their understanding of puberty-related issues and builds their skills to support their children with these issues. Take-home exercises also help facilitate communication between young adolescents and their parents. The curriculum, which was integrated into on-going life skills programs in youth-serving organizations, was implemented in Rwanda by CRS and its partner Caritas and in Guatemala by APROFAM.

The evaluation used a modified nonequivalent control group design to measure changes in knowledge, attitudes and behaviors related to puberty and fertility awareness, gender roles, intergenerational relationships, and interpersonal communication, in both parents and youth. Data was collected through individual and group interviews with an experimental and control group. Participatory learning and action exercises, including card games, modified pile sorts, storytelling and discussion of photo series were used to facilitate interviews.

Baseline results demonstrated similarities in both countries: low levels of knowledge regarding puberty, especially fertility, discomfort with puberty-related changes and lack of awareness of how gender influences SRH choices. Endline results revealed significant increases in knowledge and awareness of developmental changes, including fertility. At endline, experimental group participants were more aware of gender roles than those in the control group and more likely to challenge traditional gender roles. The intervention also improved adolescent and parents' self-efficacy related to challenging traditional gender roles through role modeling and advice-giving. Overall, results indicate that introducing topics of fertility and body awareness while weaving in gender and sexuality is an effective way to improve knowledge and increase social awareness, and leads to more healthy behaviors of boys and girls and their parents or adult guardians. What youth learn from an intervention that includes MCB can help them become more self-confident, practice good health habits, and gain a positive self-image — all of which contribute to their future SRH. Findings from this evaluation have important implications for the development of effective, feasible and replicable strategies focused on the 10-14 year old age group that has traditionally been neglected by SRH programming.

Utilizing Participatory Data Collection Methods to Evaluate Programs for Very Young Adolescents: An Evaluation of Save the Children's Choice Curriculum in Siraha, Nepal

Location: Nepal

Time period: 2010-2013

Partners: Save the Children

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“Choices” is an innovative behavior change intervention for VYAs developed and implemented by Save the Children. It is designed around eight participatory activities, and aims to change attitudes and behaviors related to negative gender norms among boys and girls participating in child clubs, a core activity of Save the Children's Adolescent Youth Development Program. IRH used a pre-posttest, quasi-experimental evaluation design to assess the effect of participation in the Choices curriculum on boys and girls. About 300 boys and girls ages 10-14 participating in child clubs were interviewed prior to the first session and one month after the final one, approximately four months later. A similar number of children who participated in child clubs that did not implement Choices were interviewed from a control area. Qualitative data was collected through in-depth interviews with 36 boys and girls from control and intervention groups at endline using visual methods (photo elicitation and projective drawing). Additionally, 24 boys and girls from control and intervention groups participated in reflexive photography

(“photovoice”) activities for the evaluation. Six focus group discussions were also conducted with parents, three in the control and three in the intervention area, to assess whether parents had noticed any changes in their children over the course of the intervention. Further key findings included:

- Most children recognized gender inequity and felt that it is unfair and should be changed. They recognized gender inequity as normal in their society and feel that Choices, or similar programs, can help to promote more gender equitable norms.
- More boys in the experimental group than the control group recognized gender inequity and said they were making small changes in their own behavior (helping their sisters and mothers with household chores, advocating for their sisters’ education and against early marriage) and that they were engaging in discussions with family members, friends and neighbors to do the same.
- More girls in the experimental area stated that their brothers and other boys in their communities were making small changes toward gender equality.
- In discussions, girls in the experimental group were more comfortable expressing their opinions than girls in the control group.
- In focus group discussions, parents in the experimental area reported that their sons had started to help their daughters with schoolwork and chores, and their households were more peaceful and harmonious as a result.

After a report was written and disseminated on the results of the study, Save the Children and IRH held a joint workshop with Save the Children field staff from six countries to discuss implementing and scaling up the Choices program.

Becoming CycleSmart: Developing an innovative tool for puberty education and fertility awareness among very young adolescents

Location: Rwanda, Guatemala, United States

Time period: 2011-2013

Partners: Guatemala: Population Council ; Rwanda: Association Rwandaise pour le Bien-Etre Famillial (ARBEF), Young Women’s Christian Association (YWCA), Hope Foundation, Associations des Guides aux Rwanda, Centres Scolaires Mpara
[Download Guatemala full report](#) / [Download Rwanda full report](#)

IRH collaborated with adolescents in Rwanda, Guatemala, and the United States to develop and test a package of tools, known as the CycleSmart Kit, to help girls and boys learn about menstruation, puberty, fertility, and staying safe. The CycleSmart Kit consists of a set of CycleBeads, a calendar, a weekly diary, reusable/washable sanitary napkins, and a country-specific CycleSmart brochure which includes topics like the menstrual cycle, puberty-related changes, and risk of pregnancy, gender norms, and safety tips.

During the first phase of the project (2011-2012), IRH and partners conducted a desk review of existing tools and materials on puberty in Rwanda and Guatemala and conducted formative research with key informants, adolescents, and parents. Additionally, the CycleSmart Kit was provided to 20 girls ages 12-14 in Rwanda and Guatemala to use for six weeks. During this time, the girls tracked their menstrual cycles using CycleBeads and the CycleSmart brochure and documented their experiences in their CycleSmart diaries. The girls then provided feedback on their experience during focus group discussions and this information was used to improve the CycleSmart Kit and develop programmatic guidelines for youth-serving organizations interested in using the CycleSmart Kit in their program activities. During phase II

(2012-2013), IRH worked with local organizations in Rwanda to evaluate the CycleSmart Kit and guidelines. A 20-item close-ended questionnaire was self-administered by 144 girls and 54 boys before and after receiving the CycleSmart Kit to measure changes in knowledge and attitudes related to menstruation, puberty, fertility, gender norms and child safety. In the United States, two focus group discussions with 14-year old adolescent girls were conducted to adapt the content from existing brochures to US-based audiences.

Results suggest that the CycleSmart Kit helped girls better understand changes occurring during their menstrual cycle, including natural secretions and menses; allowed girls to easily track their menstrual cycles and appropriately plan for their next menstruation; helped facilitate important puberty discussions between adolescents and their parents, peers and friends; was a useful tool to teach boys about puberty and fertility; and was viewed as culturally acceptable by parents. Among adolescents who completed the 20-item questionnaire, a statistically significant increase in correct responses between baseline and endline occurred on 19 out of the 20 questions (17 of which were highly statistically significant).

Providing adolescents with accurate and age-appropriate information and tools to learn about their fertility and manage their pubertal transition can empower them to make appropriate decisions about sexual behavior and protect their RH across the life course.

V. Legacy Tools

The FAM Project generated a wealth of resources on SDM, TwoDay Method and LAM for numerous audiences, most of which were developed and/or refined during the length of the six-year grant. Development of audience-specific materials—often times in partnership with the organizations that serve those audiences—has significantly contributed to establish these less known methods in the minds of policy makers, program managers, service providers and social marketing practitioners who are increasingly relying on key legacy tools to carry on FAM integration in their programs and contexts. Development of key tools also has served to standardize messages and service protocol for these methods that are used by many organizations that are looking for guidance and resources and have limited options for where to go for information on FAM. For the SDM specifically, tools for all aspects of introduction and integration, from training to client and provider resources, from evidence to guidelines were developed and tested in use in multiple countries, thus enabling IRH to make available tools based on evidence and simplified for ease of combination with other methods of FP. These resources have been thoughtfully organized and packaged into different collections that were then included in global repositories for wider use. In addition to contributing to establish an identity for these three FAM methods, packaging of legacy tools into specific collections and disseminating them through global platforms has helped provide legitimacy to the methods and ensured that accurate information can be relied upon when materials on these approaches are being adapted by organizations around the world. A selection of these tools and collections follows.

K4Health Toolkits

IRH has built or contributed to six FAM-related toolkits in the Family Planning section of K4Health's toolkits. These toolkits are valuable legacy resources that contain many of the tools and materials used throughout the FAM Project to scale-up SDM, and increase access to TwoDay Method and LAM resources. Although the FAM Project has ended, the resources remain available for programs, providers, academics, and the public in general, to access through the widely available K4Health website.

SDM

There are four SDM toolkits. The [original SDM Toolkit](#) is based on the "[Process for Integrating the SDM into Services: Essential Steps](#)" which outlines key elements that need to be in place for successful introduction and of SDM. In addition to guidelines, the toolkit makes tools and materials used at different points in the process available for adaptation and use—from training resources to advocacy pieces, to IEC materials and quality assurance checklists.

In addition to the generic, more "global level" SDM toolkit, IRH saw a need for toolkits with materials developed locally which have more regional application. The SDM tool kit in Spanish, "[Guatemala: Herramientas para la integración del MDF en programas de salud](#)" was developed using the FAM Project experience in Guatemala to provide guidelines and examples in Spanish that could be adapted by other countries in the region. Materials for training and quality assurance are downloadable, as well as examples of materials for successful IEC activities including audio of radio spots developed during the FAM Project. Similarly, with experience introducing and scaling up SDM in several francophone African countries, the French language SDM Tool kit "[Ressources et expériences de la Méthode des Jours Fixes](#)" was developed to share French-language experiences, along with materials and resources with programs interested in including SDM into the method mix. French language resources, including instructions that accompany CycleBeads, training modules, and IEC materials that can be adapted are all downloadable, as well as publications and experiences that can be used to advocate for inclusion into programs.

Lastly, an SDM toolkit with India-relevant resources, "[SDM Integration in India](#)", was developed to share the tools and resources developed specifically for the Indian context. It was deemed important to make available the experiences and materials that were unique to the India to support further program expansion. These SDM toolkits are "living document" that can be updated as new information or resources become available.

TwoDay Method

A [toolkit](#) for the TwoDay Method also is available with provider job aids, client tools, training materials, and key information about TwoDay Method. Peer-reviewed publications and research reports to date are available, as well as policies and guidelines that already include TwoDay Method on their list of modern FP methods. New information and resources can be included as they become available.

LAM

With Maternal and Child Health Integrated Program (MCHIP) and the LAM working group, IRH contributed to the [LAM toolkit](#) which provides advocacy, training and IEC tools, as well as program experiences, monitoring and evaluation guidance and existing research. Project and program managers who want to add LAM to the method mix where they are working will find resources to support the integration in this toolkit.

SDM Screening Checklist and Provider Job Aid (English, French & Spanish)

Job Aids have always been a key resource to help providers offer SDM. The [SDM Screening Checklist and Provider Job Aid](#) has evolved into a streamlined and refined version that supports quality counseling in a short 20-min session. This tool guides the provider in screening potential users for SDM use, asking simple questions to determine if her cycle is in range to use the method. In addition, it walks the provider through a simple explanation on how to use CycleBeads to the client. Available in SDM toolkits at K4Health.org as well as at www.irh.org, the SDM Screening Checklist and Provider Job Aid is one of the most important tools to make available for providers as it contains the key questions to determine if a woman can use SDM, as well all the necessary messages to pass on for a new user to use the method correctly.

CycleBeads Instructions

The CycleBeads instructions that accompany each set of CycleBeads evolved over the course of the FAM Project to be appropriate for a wider range of audiences. In addition to the original instructions in English, French and Spanish, inserts were developed in several local languages (Amharic, Bamara, Hindi, Kikongo, Kinyarwanda, Kiswahili, Kyrgyz, Lingala, Portuguese, Romanian, Somali, Swahili, Tshiluba, Urdu) using more images and fewer words. A text-only three-language instruction page (English, French and Spanish) was developed as default instructions.

CycleBeads instructions are a key tool for CycleBeads users. Providers can use the instructions as a job aid that the client can then refer back to when using CycleBeads at home, or sharing the information with her partner. The instructions are also key when CycleBeads are offered directly to the consumer, increasing access to SDM and CycleBeads.

LAM Client Card

LAM does not require any commodities to use—a LAM user needs only to meet the three criteria (mother fully or nearly-fully breast feeds her baby, her period has not returned since giving birth, and her baby is less than six months old) to effectively prevent another pregnancy. The LAM client card was developed as a dual-purpose tool, for providers to guide potential LAM users through the three criteria, and then for the woman to take home with her as a reminder of the criteria for her and to share with her partner. The LAM client card was developed at headquarters and validated in the field and is in [English](#), [French](#) and [Spanish](#). The Spanish has also been adapted for country-specific use in [Bolivia](#) and [Guatemala](#), as well as a [Hindi](#) version in India. All versions are available at www.irh.org.

WHO Medical Eligibility Criteria Wheel for Contraceptive Use

[WHO's Medical Eligibility Criteria Wheel for Contraceptive Use](#) helps to determine when a client can start using various contraceptive methods based on the *Medical Eligibility Criteria for Contraceptive Use*, 3rd

edition and its 2008 Update, one of WHO's evidence-based guidelines. It tells FP providers if a woman presenting with a known medical or physical condition is able to use various contraceptive methods safely and effectively. The wheel includes recommendations on initiating use of six common types of contraceptives.

Under the FAM Project, the wheel was adapted in to include SDM among the methods, and is used in Bolivia and Guatemala. SDM inclusion in the method mix of an additional WHO-produced FP tool continues to buoy the growing credibility of SDM and CycleBeads among providers and program managers.

IRH You Tube Channel

IRH's [YouTube Channel](#) provides public access to a number of videos on SDM, TwoDay Method and LAM that have been developed by IRH and others to enhance the teaching and learning experience of those interested in FAM. Posting the videos on YouTube expands access to videos that in the past could only be distributed by DVD/CD or VHS. The videos posted are used from supporting provider training by sharing examples and demonstrations of client/provider interaction, as well as sharing testimonials that can be used for advocacy purposes.

For SDM, several videos designed to support training providers and how to explain CycleBeads are available in English French and Spanish. The SDM Counseling video shows a typical counseling session with a provider and client, and is followed by several "special circumstance" scenarios in which the client may not be eligible to use or start SDM at the moment (i.e., has recently given birth, has recently used another hormonal method, is at risk of contracting a STI, etc.). The video is often used by facilitators when training providers to offer SDM. This video is available in English, French and Spanish.

In addition, a simple three-minute explanation of how CycleBeads work, originally developed under the AWARENESS Project to be shown in waiting rooms was made available in English, French and Spanish on the IRH YouTube Channel. This video offers a quick explanation of SDM and its benefits, and walks through how CycleBeads are used. The Spanish version of this video has viewed nearly 25,000 times in three years. IRH/India also developed a video to promote CycleTel, a SMS service using cell phones to deliver text messages indicating fertile or not fertile days to user.

IRH also able to share videos developed by others through our YouTube Channel, including an SDM waiting room video developed by Wellshare (formerly Minnesota International Health Volunteers) for the large Somali refugee population in the area, videos that support training and counseling for other FAM methods such as TwoDay Method and LAM, and advocacy messages from well-respected members of the global health community sharing their support for a given topic, such as reaching VYAs.

SDM and LAM Comic Book

As scale-up in Jharkhand, India moved forward, community health workers known as Asha's were trained to provide SDM and LAM along with some other FP methods. These community health workers use comic books to help convey information to their clients, so one for SDM and LAM was developed by IRH. The comic book describes how to provide SDM and use CycleBeads, as well as some additional chapters that describe special circumstances that may require some women to wait to use SDM. Lastly, the comic book

also includes a chapter on LAM for post-partum women wanting to use a natural method during this time. The comic book was an important piece to develop so that the tools available for providing FAM like SDM and LAM are similar, or fit into the package with other FP methods offered. The comic book is available in English and Hindi and is part of the [India SDM toolkit in K4Health's toolkit collection](#), as well as the [resource library](#) at www.irh.org.

Traditional Birth Attendant (TBA) Job Aid

In Guatemala, IRH identified traditional birth attendants as a valuable link to the community for providing important health timing and spacing of pregnancy and FP messages. The [Traditional Birth Attendant Job Aid](#) is a tool that helps TBAs discuss a range of topics such as SRH rights, fertility awareness, healthy timing and spacing of pregnancy, and FP methods available in the method mix, and provide the method or a referral. The job aid is available for download in the [Spanish language SDM toolkit](#) in K4Health's toolkit collection, as well as the resource library at www.irh.org.

Paper SDM

From 2009-2011, IRH collaborated with FHI360's C-Change Project to test a paper version of SDM that could be distributed directly to potential users, raising awareness of the method, and encouraging them to try SDM and/or talk to their provider about FP. Using salons and kiosks as an outlet to reach women who would be interested in FP helps to widen the reach of the importance of FP. The paper SDM contained all the information and messages needed by the user to understand how to use SDM and the Paper SDM image to track the days of her cycle to know if she is on a fertile day or not. The paper SDM was distributed in hair salons and kiosks in Cotonou, Benin as a tool to create awareness for SDM and CycleBeads, allowing women who took a copy with her to learn about the method, try using it for two cycles, and then possibly visiting her provider or pharmacist to purchase plastic CycleBeads. The tool showed to be effective in raising awareness for the method, as well as encouraging users to inquire about FP with their providers. The [paper SDM](#), along with the report, is available for download at www.irh.org and could be adapted for similar use in other settings.

Standard Days Method Training Resources CD

Many tools for training in SDM have been developed over the years, modified for many reasons including simplification and shortening the length of the workshop. However, the most necessary modification has been to adapt the training for a wide variety of audiences from medical doctors, to high-level service providers, to community health workers, to nursing and medical students. Each of these trainings were modified to meet the needs of each audience, and compiled into a collection available on CD called "Standard Days Method Training Resources CD." The CD contains PDF copies of training manuals, participant notebooks, provider job aids and client tools, as well as links to some on line resources that may be useful for some audiences, such as the SDM Online Training. Availability of all these training resources in one collection allows the user to have all the materials he/she needs at his/her disposal to train in SDM, as well as keep in mind what is available for other audiences they may not have previously considered.

www.naturalfp.com

[Naturalfp.com](http://www.naturalfp.com) is a website developed to support Catholic groups interested in training NFP teachers to provide SDM and TwoDay Method. The materials on this site have been revised to accommodate

requirements of Catholic teachers and users. Strategically, NFP teachers and the Catholic community are a target audience for FAM. It is important to make sure materials that are appropriate for their needs are available. NFP teachers who visit this site can read the materials provided and complete a post-test and practicum assignment for a certificate of completion in both SDM and TwoDay Method. Client and provider materials as well as peer-reviewed publications are downloadable.

FAM Project legacy in global RH/FP resources

IRH also maintained on-going collaboration with organizations at the global, country and domestic levels to include FAM in international guidance documents, training curricula and state of the art job aids.

Illustrative examples of efforts include:

- Fertility awareness information—as it relates to the menstrual cycle and hygiene—added to the Women’s Health training module for factory workers developed by BSR’s [HER+Project](#).
- SDM and My Changing Body modules added to the Peace Corps Webex recorded training that is available to volunteers in the field. New volunteers in Latin America and Africa joined yearly synchronous webinars before the module was integrated in 2012 in Peace Corps’ ongoing webinar series.
- SDM and TwoDay Method modules are featured in the [CORE Group Webinar series](#) as part of an initiative to offer routine contraceptive technology updates to CORE Group members in the field.
- A section on SDM and natural methods included in the Association of Reproductive Health Professionals (ARHP) [Method Match Tool](#)
- DHS questionnaire was revised to be more inclusive of SDM. The new version in Section 3 Contraception includes a clear probe for SDM, and instructions on how to include SDM in the questionnaires for countries that wish to do so. The probe for Rhythm has been revised to avoid confusion with SDM. This will result in a uniform inclusion of SDM in future surveys, allow for clear distinction between SDM and Rhythm Method users, and provide accurate data for decision-making.
- SDM and NFP Couple Years of Protection conversion factors were updated by the Futures Institute with support from IRH to use evidence from SDM studies to adjust the conversion factor for SDM to 2.0 CYPs rather 1.5 used for all NFP methods. New guidance to programs from USAID was released with new figures to report their CYP for SDM.
- Through continuous collaboration with different WHO committees, SDM, TwoDay Method and/or LAM were updated in WHO’s five cornerstone documents existing documents or added in new guidance documents, including an Advisory Note for CycleBeads procurement for CycleBeads.

Appendix A

IRH invited to speak about FAM in presentations at international and regional meetings

2009				
Meeting Title	Location	Presentation Title or meeting description	Date	FAM method
LAM Working Group Meeting	Washington, DC	“Lactational Amenorrhea Method (LAM) Measurement: Household and Health Facility Surveys and Indicators”	July 2008	LAM
Technical Update at Abt Associates	Washington, DC	IRH invited to speak at Abt Associates about IRH’s work, technical update for Abt staff & brainstorming for future collaborating	July 18, 2008	LAM, SDM, TDM
Technical Update at Macro International	Washington, DC	IRH invited to speak at Macro about IRH’s work, technical update for Macro staff	August 18, 2008	SDM, LAM, TDM
Key Messages for Post-Partum Family Planning Online Forum, IBP Initiative	Washington, DC	“Repositioning LAM as a gateway to other methods”	Sept. 2008	LAM
Brown Bag on HTSP and Contraceptive Use at World Vision	Washington, DC	“Expanding FP options to include HTSP” IRH presented on SDM and LAM in programs, especially in the context of HTSP, and the collaborative work of World Vision and IRH in India.	March 23, 2009	LAM, SDM
Technical Update at Jhpiego	Baltimore, MD	IRH invited to speak at Jhpiego about IRH’s work, technical update for Jhpiego staff & brainstorming for future collaboration	April 27, 2009	SDM, LAM
Peace Corps Training	Washington, DC (on WebEx)	Introducing the SDM into Peace Corp Programs – informing Peace Corps country managers (Guinea, Suriname, Botswana and Cameroon)	April 29, 2009	SDM
CCIH Conference	Buckeystown, Maryland	Annual meeting, “SDM and LAM: Options for faith-based programs”	May 25, 2009	SDM, LAM
Pediatric Grand Rounds	Children’s Hospital, Washington DC	Global Health Course Series, “Impact of Birth Spacing on Maternal and Child Health”	April 1, 2009	LAM
Core Group/Interagency Working Group on Healthy Timing and Spacing of Pregnancy	Washington, DC	Presentation on how HTSP is integrated into SDM and LAM tools, guidelines, and IRH’s technical assistance	April 2009	LAM, SDM
Ministry of Health Guatemala and WHO/ExpandNet Meeting	Guatemala City, Guatemala	“Colaboración entre Socios para la incorporación de métodos de conocimiento de la fertilidad en Guatemala”	May 2009	SDM

WHO/ExpandNet Meeting on Scaling up	Ann Arbor, Michigan	IRH's research design, plan, and challenges for national level scale up IRH's research design, plan, and challenges in measuring process and outcomes of scaling up	May 6-8, 2009	SDM
Postpartum Family Planning: Sharing Experiences, Lessons Learned, and Tools for Programming	Baltimore, Maryland (Jhpiego)	"Repositioning LAM, Interagency LAM Working Group"	May 12, 2009	LAM
Human Reproduction Programme, World Health Organization	Geneva, Switzerland	"Latest Research on the Standard Days Method for Contraception"	June 2009	SDM
Congress of Peru	Peru	Presentation of IRH's history in Peru dating back to Awareness. Research was presented on CPR in Peru, Advantages of distance learning, Implementation of SDM Self Study manual by COP and its evaluation.	July 2009	SDM
Pediatric Grand Rounds	Children's Hospital, Washington DC	Global Health Course Series, "Impact of Birth Spacing on Maternal and Child Health"	August 20, 2009	LAM
LAM Working Group meeting	Washington, DC	Developing names for LAM indicators and standardizing measurement	August 20, 2009	LAM
WHO/EMRO meeting	Jordan	IRH invited to give overview of FP in EMRO/MENA region and IRH's experience in the region	September 28, 2009	SDM
FIGO Conference	Cape Town, South Africa	"Changing Roles of Clinical Providers in Expanding Family Planning Access and Choice" Task shifting experiences with SDM	October 2009	SDM
APHA	Philadelphia, PA	"Lactational Amenorrhea Method (LAM): Friend or Foe of Family Planning?" "Revitalized LAM Approach: Increasing Quality Services for Facility and Community-Based RH and Maternal-Newborn Programs" "Understanding Scaling Up: Research and Programmatic Challenges" "Fertility awareness method use: Gender, pleasure and shifts in intimate relationships" "Use of private sector approaches and ICT as a scale-up strategy for family planning: Focus on India"	November, 2009	LAM

		“Family planning when “green” is queen: Exploring the potential for fertility awareness-based methods (FAM) in U.S. Title X clinics”		
International Conference on Family Planning (ICFP)	Kampala, Uganda	<p>“Family planning via mobile phones: Proof-of-concept testing in India”</p> <p>“Policy imperatives for systems-oriented approaches to scaling up: Case example of taking the SDM to national scale”</p> <p>“Fertility Awareness Based Methods and Gender”</p> <p>“Evaluating programs reaching very young adolescents: Experiences and lessons from My Changing Body”</p> <p>“Bringing New People to Family Planning with LAM and SDM”</p> <p>“Community and Social Change in ASRH Programs: Strategies for Measuring Change”</p> <p>“Scaling Up From the Start: Beginning with the End in Mind”</p> <p>“Using Communication to Address Gender Norms – Focus on Couple Communication and Male Involvement”</p>	November, 2009	SDM, LAM
Georgetown University Alumni meeting	New York City, NY	The Millennium Development Goals and cura personalis: Addressing global health challenges from research to practice	November 2009	Cross-cutting
2010				
Meeting Title	Location	Presentation Title or meeting description	Date	FAM method
USAID Staff Meeting	Washington, DC	Measuring Women’s Empowerment in the Context of Family Planning: Contributions of Research on the Standard Days Method	January, 2010	SDM
USAID Staff Meeting	Washington, DC	FAM Research to Scale	January, 2010	SDM
Maternal Child Health Course	George Washington University, Washington DC	"Impact of Birth Spacing on MCH"	February 22, 2010	LAM/SDM
Reconvening Bangkok: 2007 to 2010- Progress Made and Lessons Learned in Scaling-Up	Bangkok, Thailand	Scaling up an Innovation: Experience with the Standard Days Method® of Family Planning	March 8, 2010	SDM

FP/MNCH Best Practices in the Asia and Middle East (AME) Region				
Reconvening Bangkok: 2007 to 2010- Progress Made and Lessons Learned in Scaling-Up FP/MNCH Best Practices in the Asia and Middle East (AME) Region	Bangkok, Thailand	Lactational Amenorrhea Method (LAM) : A critical yet underutilized element of maternal and infant health	March 8, 2010	LAM
Peace Corps 2010 Resource Marketplace at the Global Programming & Training Officers' Conference	Washington, DC	Introducing the SDM into Peace Corp Programs	March, 2010	SDM
FHI ROADS Project Retreat	Kigali, Rwanda	FAM Project Technical Assistance to Non-Scale up Programs	March, 2010	Cross-cutting
NIH Conference on the Science of Dissemination and Implementation: Methods and Measurement	Washington, DC	Scaling up new family planning methods: untangling metrics and monitoring approaches	March 17, 2010	SDM
Society for Applied Anthropology	Merida, Mexico	Don't fear the tear: Possibilities for agency and resistance among 10-14 year old boys	March 24, 2010	Cross-cutting
Psychosocial Workshop	Dallas, Texas	The Standard Days Method, women's empowerment, and contraceptive prevalence	April 2010	SDM
Annual Meeting of the Inter-agency Working Group on RH in Crises	Santo Domingo, Dominican Republic	Use of Fertility Awareness Based Family Planning Methods in Areas of Conflict and Civil Unrest: Examples of Haiti and the Democratic Republic of Congo	May 2010	SDM
Global Health Council	Washington, DC	Promoting HTSP while Expanding Family Planning Options	June 2010	LAM
Global Health Council	Washington, DC	Scaling up with the endpoint in mind: What every program should consider in terms of principles	June 2010	Cross-cutting
Christian Connections for International Health Annual Conference	Buckeystown, Maryland	Annual meeting, "Orientation on SDM, TDM and LAM"	June 11, 2010	SDM, TDM, LAM
Christian Connections for International Health Annual Conference	Buckeystown, MD	Faith, family planning and family well-being: Maximizing effectiveness through collaboration (panel)	June 7, 2010	Cross cutting
Where Faith and Science Meet, Catholic Bishops Conference	Milwaukee, Wisconsin	Status of NFP in the U.S. and the World: A review of data from the National Survey of Family Growth and the Demographic and Health Surveys	July 2010	FAM

		Strategic Approach to SDM Introduction: Expanding the Availability and Use of FAM		
Georgetown University: Implementation Science Meeting	Washington, DC	Scaling up an Innovation: Experience with the Standard Days Method® of Family Planning, presentation with ExpandNet	July 2010	FAM
APHA	Denver, CO	Integration of family planning with health facility and community-based services: Multi-country data on LAM counseling and postpartum family planning When do you know if a new family planning service is really available? Shifting Gender Norms in Nepal to Improve Health and Development of Very Young Adolescents Strengthening VCT services by addressing stigma and discrimination	October 2010	FAM
USAID Mini University 2011	Washington, DC	Leave those surveys behind! Key issues to consider in evaluating VYA programs CycleTel™: My Mobile Phone is My Family Planning Method	October 2010	SDM
Men, Masculinities and Family Planning Conference, UCLA	UCLA, California	Engaged and Engendered: Women, Men, and Child Spacing in Mali	October 2010	FAM
2011				
Meeting Title	Location	Presentation Title or Meeting Description	Date	Topic
mHealth Working Group Meeting	Washington, DC	CycleTel™ in India: From Proof-of-Concept to Deployment	January 2011	SDM
USAID Staff Meeting	Washington, DC	Contributing to Innovation and Sustainability: Building Evidence through Implementation and Social Science Standard Days Method (SDM): From Research To Scale- Up (USAID Staff Meeting, January 2010) Measuring Women's Empowerment in the Context of Family Planning: Contributions of Research on the Standard Days Method (USAID Staff Meeting, January 2010)	January 2011	Cross-cutting
5th Biennial Africa Christian Health	Accra, Ghana	Expanding and Strengthening Family Planning in Comprehensive Health Services: New Approaches!	February 2011	SDM, LAM

Associations Platform conference		IRH conducted a pre-conference CTU which introduced SDM for the first time to representatives from Christian Health Associations.		
Population Association of America	Washington, DC	Introducing a new method into the family planning method mix – effect on women’s empowerment and contraceptive prevalence	March 2011	SDM
Symposium on mHealth Strategy for LAC	Lima, Peru	iCycleBeads™ y CycleTel™: Tecnología móvil para la planificación familiar	March 25-26, 2011	SDM
USAID Integration Meeting	Washington, DC	Lactational Amenorrhea Method (LAM), Exclusive Breastfeeding and the Transition, To Other Family Planning Methods	March 30, 2011	LAM
Pediatric Grand Rounds	Children’s Hospital, Washington DC	Global Health Course Series, “Impact of Birth Spacing on Maternal and Child Health”	March 29, 2011	LAM
Young Adolescents dissemination meeting	Guatemala City, Guatemala	Resultados de la evaluación de “Mi Cuerpo está Cambiando”	April 8, 2011	Cross-cutting
Tech Salon	Washington, DC	IRH was invited to speak with ThoughtWorks at the Tech Salon, hosted by Invveno. The topic of the discussion was "Spice Up Your Next Proposal with Software!", and IRH was able to speak to a new audience about CycleTel.	May 2011	SDM
Georgetown Medical School Course	Washington, DC	Lecture title: "LAM Evidence, Research, and Background"	May 1, 2011	LAM
Technical consultation on Research/Programs for VYAs de 10-14 años: “Planeando para la diversidad”	Guatemala	El mundo de los y las jóvenes	June 10-11, 2011	Cross-cutting
Expert Meeting on Essential Elements for Monitoring and Evaluation of Scale-up	Washington, DC	IRH co-hosted, with USAID, a technical consultation on the M&E of Scale-up during the IBP meeting. IRH presented on our M&E strategy with SDM.	June 2011	SDM
Global Health Council Conference	Washington, DC	Faith, family planning and family well-being: Maximizing effectiveness through collaboration (roundtable)	June 15, 2011	Cross-cutting
International Confederation of Midwives Conference	Durban South Africa	IRH hosted a training workshop as an auxiliary FAM training for SDM, TDM and LAM. IRH, along with Jhpiego, Pathfinder/ESD Project, MSH, and World Vision, presented a panel titled, “Advancing Family Planning through Healthy Timing and Spacing of Pregnancy”.	June 2011	Cross-cutting
Reproductive Health Supplies Coalition Annual Conference	Addis Adaba, Ethiopia	Achieving Security for SDM/CycleBeads in Rwanda and Mali: Untangling	June 20-24, 2011	SDM

		Procurement, Distribution, and Policy Issues	
WHO Regional Scale-up Meeting	Bangkok, Thailand	Monitoring and Evaluating Scale-Up of a Reproductive Health Innovation	July 2011 SDM
2012			
Meeting Title	Location	Presentation Title/ Meeting Description	Date
USAID Partners Meeting on M&E of Scale-up	Washington, DC	Monitoring and Evaluating Scale-up: Issues at the Global and Country level	January 2012
E2A Technical Meeting	Washington, DC	Process Documentation: Lessons from a Prospective, Multi-site Case Study	June 2012
Celebrating Men as Fathers and Allies in Gender Equality and Improved Health	Washington, DC	Building Gender Equity and Promoting Responsible Fatherhood in Family Planning Programs	June 2012
IBP Meeting	Washington, DC	Scale-Up of the Standard Days Method (SDM): What, How & So What	June 2012
2013			
Meeting Title	Location	Presentation Title/ Meeting Description	Date
Sandbox Meeting	Washington, DC	Family Planning on a Mobile Phone? Challenges and Opportunities	January 18, 2013
WHO Experts Group	Geneva	Program Research with Very Young Adolescents	February 4-6, 2013
DRC FAM Project Dissemination Meetings	Kinshasa, DRC	WHO/ExpandNet Framework: A Systematic Approach for Scaling-Up SDM in DRC" The Level of SDM Scale-Up in DRC: Progress through 2013 Lessons Learned from the Scale-Up of SDM in DRC" The FAM Project in DRC: Sustainable Integration of SDM	February 8, 2013
Health 2.0 India	Bangalore, India	"Content, Mobile and Real Life" panel, feature on CycleTel	February 9, 2013
Guatemala FAM Project Dissemination Meetings	Guatemala City, Guatemala	Meeting to support FP Resource Team in planning transition activities related to FAM integration Dissemination of SDM Scale-Up Case Study and FAM research studies Workshop on Adolescent Sexual and Reproductive Health strategies and materials	February 14-22, 2013

Consortium of Universities for Global Health (CUGH)	Washington, DC	Extending the reach of the health system: the promise of mHealth	March 15, 2013
Rwanda FAM Project Dissemination Meetings	Kigali, Rwanda	<p>The ExpandNet/WHO Framework for Scaling Up</p> <p>SDM Scale Up in Rwanda: Applying the ExpandNet Model</p> <p>The Level of SDM Scale-Up in Rwanda: Progress through 2013</p> <p>Very Young Adolescents: Puberty, Fertility, Gender Awareness and the Sexual and Reproductive Health</p> <p>Technical Assistance and Partnerships: Introducing SDM in East and West Africa</p> <p>Introducing SDM in East, Central and Southern Region through the East, Central and Southern Africa College of Nursing (ECSACON)</p> <p>Costing the Standard Days Method in Rwanda</p>	March 26, 2013
Population Association of America	New Orleans, LA	The power of influence: Social network perspective on men's and women's attitudes toward contraceptive use	April 11-12, 2013
Save the Children	Washington, DC	Becoming CycleSmart: Developing an innovative tool to help girls learn about and manage their menstruation	April 22, 2013
CORE Group Spring Meeting	Baltimore, MD	Power Breakfast Roundtable: CycleSmart	April 23, 2013
Peace Corps	Washington, DC	Becoming CycleSmart: Developing an innovative tool to help girls learn about and manage their menstruation	April 24, 2013
End of Project meeting with FHI360 on mobile innovations under the FAM and PROGRESS projects	Washington, DC	CycleTel: Research Review and Findings	May 23, 2013
India FAM Project Dissemination Meetings (District)	Jharkhand, India	<p>Experience Sharing: Integration of SDM and LAM into Family Planning Services in Jharkhand</p> <p>Costing the Standard Days Method in India</p>	May 28, 2013
USAID Bureau PEC, CSL, SDI team meetings	Washington, DC	Supporting the Standard Days Method at Scale: What's left to do	June 25, 31, 2013
Fertility Awareness Technical Consultation	Washington, DC	<p>Let's Talk about Fertility Awareness</p> <p>Fertility Awareness Through the Life-cycle: What people know, what they DON'T know, and how it influences their attitudes and behaviors related to SRH</p>	July 9, 2013

India FAM Project Dissemination Meetings (Ranchi)	Ranchi, India	Expanding Choices & Increasing Access to Contraception Increasing Access by Integration & Scale up of FAM in Public Sector – The Jharkhand Experience Sustaining Scaling Up - what does it take?	July 9, 2013
MSI and USAID Presentation	Washington, DC	Meeting the Need for Family Planning: Fertility Awareness Methods	July 16, 2013
India FAM Project Dissemination Meetings (Delhi)	Delhi, India	Increasing Access to Family Planning Through Scale Up of Innovations	July 17, 2013
USAID Meetings	Washington, DC	SDM Scale up in Jharkhand: A Prospective 5 year case study Strategic Scale up of SDM in Rwanda	July 23, 2013
Fertility Awareness-based Methods (FAM) Project End of Project Meeting	Washington, DC	Promising Practices for Sustainable Scale-Up: A Prospective Case Study of SDM Integration Changing the paradigm for technical assistance (TA) Responding to the environment Making strategic service delivery choices Ensuring innovation values remain during scale up: Male involvement, women's empowerment, and gender	July 25, 2013
MCHIP Brown Bag Lunch	Washington, DC	Promising Practices in Monitoring, Learning & Evaluation: The Art & Science of Scale-Up	September 2013
Reproductive Health Supplies Coalition Fourteenth Meeting, 2013	Delhi, India	Systems Approach to Contraceptive Introduction: A Case Study of SDM Integration	October 7-11, 2013
Systems Approaches for Scale-Up Webinar Series (host: E2A, IBP Initiative)	Global	Promising Practices for Scaling Up a Reproductive Health Innovation	October 9, 2013
Scaling up Mobile Technology Applications for Accelerating Progress on Ending Preventable Maternal and Child Death, USAID	Addis Ababa, Ethiopia	Harnessing the Viability Lens: A CycleTel case study	November 10, 2013
Family Planning + Social Good: FHI360,	Addis Ababa, Ethiopia	Mobile Technology, a connected chat	November 12, 2013

Packard Foundation, UN Foundation			
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IRH abstracts accepted at international and regional meetings to present on FAM research and program results

2009			
Conference	Date/Location	Abstract Accepted	Poster/ Presentation
Global Health Council	May 26-30, 2009 Washington, DC	Panel presentation on approaches, tools, and evaluation methodologies for working with very young adolescents in SRH issues: “Innovative methods improving youth adolescents’ body literacy and fertility awareness”	Panel presentation
International Conference on Mother & Neonatal Survival (MOH Rwanda, George Washington University, Rwanda Medical Association)	May 25-27, 2009 Kigali, Rwanda	Expanding FP to include HTSP	Presentation
Psychosocial Workshop (PAA)	April 28-29, 2009 Detroit, MI	Using qualitative methods to examine scale-up: Application of the ExpandNet framework and MSC methodology	Presentation s
Global Symposium on Engaging Men and Boys in Gender Equality	March 30-April 3, 2009 Rio de Janeiro, Brazil	The ABCs of Body Literacy, Gender, and Sexuality for Youth	Poster
International Conference on Scaling-up of health programs in low-income countries	December 3-6, 2008 Dhaka, Bangladesh	Applying a strategic approach to scale-up	Presentation
APHA Annual Meeting	October 25-19, 2008 San Diego, CA	It takes a village: Community workers increase birth spacing knowledge and use in India Research to Practice to Sustainable Scale-Up: Managing the Process with the Standard Days Method Family Planning Training: What comes next? Comparison of cost-effectiveness of 3 forms of refresher trainings in Guatemala Using Cognitive Interviews to improve service delivery tools: The simplification of SDM screening Promoting gender equity by expanding family planning choice through fertility awareness-based methods: Experiences from Guatemala, Peru and India	Presentation s and Posters

Association of Reproductive Health Professionals (ARHP) Annual Conference	September 17-20, 2008 Washington, DC	Can a User-Friendly Natural Method Help Increase Real Access to Family Planning?	Poster and Presentation
European Congress on Fertility Awareness-Based Methods	September 6, 2008 Antwerp, Belgium	Natural methods, gender, and sexuality A quick-start approach to the TwoDay Method Computer-based NFP training for healthcare professionals	Presentations
St. Louis University's Humanae Vitae Conference	July 2008 St. Louis, MS	Getting more bang for your effort: Towards sustainable NFP services in limited-resource settings	Presentation
2010			
Conference	Date/Location	Abstract Accepted	Poster/Presentation
International Conference on Urban Health	October 18-23, 2009 Nairobi, Kenya	"Family planning by text messages: Proof-of-concept testing "	Presentation
International Federation of Gynecology and Obstetrics (FIGO) Conference	October 4-9, 2009 Cape Town, South Africa	"Changing Roles of Clinical Providers in Expanding Family Planning Access and Choice"	Presentation
National Association of Nurse Practitioners in Women's Health (NPWH) Conference	October 14-17, 2009 Washington, DC	"Meeting clients' needs for FP without hormones: Opportunities for introducing SDM/CycleBeads"	Presentation
USAID Global Health Mini-University	October 9, 2010 Washington, DC	"Whose choice is it anyway? Informed Choice Re-examined"	Presentation
APHA Annual Meeting	November 7-11, 2009 Philadelphia, PA	Strengthening VCT services by addressing stigma and discrimination When do you know if a new family planning service is really available?: Challenges in tracking availability of a new service and new users during scale up from pilot to national level Integration of family planning with health facility and community-based services: Multi-country data on the extent of Lactational Amenorrhea Method (LAM) counseling and postpartum family planning Potential effect of male attitudes on family planning choice in Mali and India: Views on a fertility awareness method	Presentations and Posters

		<p>Strategic Approach to Contraceptive Introduction: Offering SDM in Title X clinics</p> <p>Women's empowerment and family planning use: Effects of Standard Days Method integration in India and Peru</p>	
International Conference on Family Planning (ICFP)	<p>November 15-18, 2009 Kampala, Uganda</p>	<p>"Fertility Awareness-based Methods and Gender"</p> <p>"Family planning via mobile phones: Proof-of-concept testing in India"</p> <p>Promoting healthy timing and spacing of pregnancy (HTSP) while expanding family planning options</p> <p>"Evaluating programs reaching very young adolescents: Experiences and lessons from My Changing Body"</p> <p>"Integration of family planning with health facility and community-based services"</p> <p>"Policy imperatives for systems-oriented approaches to scaling up: Case example of taking the SDM to national scale"</p>	<p>Presentation</p> <p>Presentation</p> <p>Presentation</p> <p>Presentation</p> <p>Poster</p> <p>Presentation</p>
American Evaluation Association	<p>November 14, 2009 Orlando, FL</p>	<p>"Evaluating Scale Up in International Health Programs"</p>	<p>Presentation</p>
Psychosocial Workshop (PAA)	<p>April, 2010</p>	<p>"The Standard Days Method, women's empowerment, and contraceptive prevalence"</p>	<p>Presentation</p>
Inter-agency Working Group on RH in Crises	<p>May 2010</p>	<p>"Use of Fertility Awareness Based Family Planning Methods in Areas of Conflict and Civil Unrest to expand options and address supply issues: Examples of Haiti and the Democratic Republic of Congo"</p>	<p>Presentation</p>
Christian Connection for International Health	<p>June 11-13, 2010 Buckeystown, Maryland</p>	<p>"Orientation on SDM, TDM and LAM"</p>	<p>Presentation</p>
Global Health Council	<p>June 15 -19, 2010 Washington, DC</p>	<p>"Promoting HTSP while Expanding Family Planning Options"</p>	<p>Panel presentation</p>

2011

American College of Nurse-Midwives (ACNM)	May 24-28, 2011 San Antonio, TX	Distance Learning: A low-cost option for closing the knowledge gap	Poster
Society for Menstrual Cycle Research Conference	June 2011, Pittsburgh, PA	Low Tech/High Empowerment: Menstrual cycle product increases fertility awareness, serves as a method of family planning, and supports gender equity	Presentation
Global Health Council Conference	June, 2011 Washington, DC	Faith, family planning and family well-being: Maximizing effectiveness through collaboration	Presentation
RHSC Coalition Membership Meeting, Panel for Caucus	June 2011 Addis Ababa, Ethiopia	Achieving Security for SDM/CycleBeads in Rwanda and Mali: Untangling Procurement, Distribution, and Policy Issues	Presentation
International Confederation of Midwives conference	June 2011 Durban, South Africa	Advancing Family Planning through Healthy Timing and Spacing of Pregnancy	Presentation
2012			
Conference	Location/ Date	Abstract Accepted	Poster/ Presentation
Society for Menstrual Cycle Research	Pittsburgh, PA July 2011	Low Tech/High Empowerment: Menstrual cycle product increases fertility awareness, serves as a family planning method, and supports gender equity	Presentation
National Title X FP Conference	Miami, FL August 2011	Introducing CycleBeads in Title X Clinics: Preliminary findings of an OPA-funded NFP study	Presentation
Global Implementation Conference	Washington, DC August 2011	What Influences Scale up? Results of a Prospective Study Assessing Scale up Processes and Outcomes in Five Countries	Presentation
APHA	Washington, DC November 2011	CycleTel in India: Effective Family Planning on Mobile Phones Expanding Access to Family Planning in Non-Traditional Settings: Offering the Standard Days Method in Small Shops (Boutiques) in Rural Mali	Presentation Poster
APHA	San Francisco, CA October 2012	Taking advice from those they trust: Traditional Birth Attendants as family planning promoters and providers in rural Guatemala	Presentation
American Evaluation Association Conference	California November 2011	Using Most Significant Change methodology to evaluate the impact of scaling up of a health innovation in four Countries	Presentation
International Conference on Family Planning	Dakar, Senegal December 2011	No-commodity, no-cost family planning: the TwoDay Method Contraceptive Security and Family Planning	Presentation Presentation

		<p>Systems Strengthening in Conflict and Post-Conflict Settings: Expanding Access to Fertility Awareness Methods in the Great Lakes Region of Africa</p> <p>CycleTel™: Family planning on mobile phones, from development to deployment</p> <p>Engaging Men in Family Planning</p> <p>At the Nexus Between Child and Sexual and Reproductive Health: Foundational Programs for VYAs</p> <p>Using Most Significant Change Methodology to Evaluate the Impact of Scaling up a Family Planning Innovation in Five Countries</p> <p>How Do You Know Success? Guidelines and Tools for Evaluating Youth Programs</p> <p>Combining Social Mobilization with Services to Introduce Family Planning into Muslim Communities in the DRC</p> <p>What Influences Scale up? Mid-term Results of a Prospective Study Assessing Scale up Processes and Outcomes of a Family Planning Innovation in Four Countries</p> <p>Is a Lactational Amenorrhea Method (LAM) User Card an effective strategy for improving LAM uptake and facilitating the transition to other family planning methods?</p> <p>The Rocky Road to Scaling up- Pitfalls and Lessons Learned</p> <p>An insider's point of view: Using ethnographic methods to understand unmet need</p>	<p>Presentation</p> <p>Presentation</p> <p>Presentation</p> <p>Presentation</p> <p>Presentation</p> <p>Presentation</p> <p>Poster</p> <p>Poster</p> <p>Presentation</p> <p>Poster</p>
e-Health Africa Conference - Integrating m-Health into e-Health Strategy Implementation	Nairobi, Kenya April 2012	CycleTel™: mHealth Lessons Learned from Developing and Deploying a SMS-based Family Planning Service	Poster
MWPHA 2012 Annual Meeting	Washington, DC May 2012	Increasing Efficiency and Utilization of Family Planning Services through Systematic Integration	Presentation
CORE Group Annual meeting	Wilmington, DE May 2012	mHealth for Community Health: The Nuts & Bolts Behind Success	Presentation

CORE Group Annual meeting	Wilmington, DE May 2012	Promoting Evidence-Based Health Programs for Very Young Adolescents	Presentation
InterReligious Council of Kenya	Nairobi, Kenya May 2012	Faith-based Organizations as Partners in Family Planning: Working Together to Improve Family Well-being	Presentation
Christian Connections for International Health Annual Conference	Arlington, VA June 2012	Revitalizing family planning in Christian Health Associations through community health workers and religious leaders	Presentation
2013			
Conference	Location/ Date	Abstract Accepted	Poster/ Presentation
Christian Connections for International Health Annual Conference	Arlington, VA June 2013	Becoming CycleSmart: An innovative tool to promote puberty awareness among girls	Presentation
Society for Menstrual Cycle Research	New York, NY June 6-8	Becoming CycleSmart: Developing an innovative tool to help girls learn about and manage their menstruation	Presentation
American Public Health Association Annual Meeting: Think Global, Act Local	Boston, MA November 4-6	Promoting body literacy and fertility-awareness among very young adolescents	Roundtable, Presentation
International Conference on Family Planning	Addis Ababa, Ethiopia November 10-16	Using Program Evaluation Data for Mid-Course Corrections of a Complex Program: Scaling up Standard Days Method in Rwanda From Product Innovation to Market Validation: Assessing Market-Based Viability for Bringing a New Contraceptive Method to Market in India	Poster
International Conference on Family Planning	Addis Ababa, Ethiopia November 10-16	Using social diffusion approaches to decrease social barriers to family planning use: Experiences and evaluation of the 'Each One Invites 3' campaign in Rwanda The TwoDay Method® Community Study: Adapting tools for successful community-based delivery of the TwoDay Method® Evaluating programs for youth: Age-appropriate, participatory methods Beyond standard monitoring and evaluation: Supporting scale up with data	Presentation

		<p>Becoming CycleSmart: Promoting Puberty Education and Fertility-Awareness Among Very Young Adolescents</p> <p>Does fertility awareness decrease the likelihood of an unintended pregnancy?: Results from Azerbaijan, Bolivia, Cameroon, DRC, Morocco and the Philippines</p> <p>A fertility-awareness approach to postpartum family planning: transition to the Standard Days Method®</p> <p>Standard Days Method/CycleBeads: A Strategic Approach for Getting to Scale</p> <p>CycleTel: Expanding Family Planning Method Access via Mobile Phones</p> <p>Becoming CycleSmart: An innovative tool to increase fertility-awareness and puberty knowledge among very young adolescents</p> <p>Making the Business Case to the Private Sector</p>	
MOH of Tanzania's Family Planning Conference	Arusha, Tanzania October 9-11	<p>Standard Days Method®: Using Advocacy to Reduce Unmet Need for Family Planning</p> <p>CycleTel: Expanding Family Planning Access through Mobile Phones</p> <p>Using Program Evaluation Data for Mid-Course Corrections of a Complex Intervention: Standard Days Method in Rwanda</p>	Presentations and Poster
American Evaluation Association	Washington, DC October 16-19	Linking Scale up Theory to Scale Up M&E: Methodological Findings From a Five-country Prospective Study of Scaling Up of a Reproductive Health Innovation	Presentation
mHealth Summit	Washington, DC December 8-10	From Starting to Sustaining: Models for Low and Middle Income Countries: CycleTel Marketing Validation Testing	Presentation

Appendix B

IRH Interagency Working Group Participation through life of FAM Project

WORKING GROUP NAME	AFFILIATION
American Evaluation Association (AEA)	Global
American Public Health Association	Global
AYSRH Coalition/Advocacy Group	Global
Christian Connections for International Health, Affiliate	Global
Contraceptive Security Working Group	USAID
CORE Group Working Group: Adolescent Health Task Force	Global
CORE Group Working Group: HIV/AIDS	Global
CORE Group Working Group: M&E	Global
CORE Group Working Group: Safe Motherhood/RH	Global
CORE Group Working Group: Social and Behavior Change	Global
East, Central and Southern Africa Health Community	Global
Georgetown and Africa Interest Network	Georgetown University
Georgetown and India Working Group	Georgetown University
Global Health Communicators Working Group	USAID
Global Health Council, Member	Global
Global Health Council Faith and Global Health Caucus	USAID
Global Health Initiative-Family Planning Best Practices Initiative	USAID
Global Health Initiative-Family Planning Best Practices Initiative	USAID
HipNet	USAID
HIP Technical Advisory Group	USAID
HTSP Working Group	USAID
IAWG on Reproductive Health and Conflict	UN
Implementing Best Practices (IBP) Consortium	UN
IBP's M&E Task Team	Global
IBP's Fostering Change for Scale-Up Task Force	Global
IBP's High Impact Practices (HIPs) Task Force	Global

Interagency Youth Working Group	USAID
Knowledge Management Working Group	USAID
Market Development Working Group	Global/RHSC
M&E Working Group	USAID
mHealth Alliance Advisory Board	Global
mHealth Working Group	USAID/Global
MYCIN/FP (Formerly LAM WG, now focusing on integration)	USAID
New and Underutilized Methods Caucus	Global/ RHSC
Reproductive Health Supplies Coalition	Global
Reseau African Sante Pop	Regional (Africa)
Social Media for Global Health Working Group	Global
Social Media Interagency Working Group	USAID/Global RH
WHO PPC	UN

Appendix C

Global partners incorporating FAM into their programs (i.e. service protocols, IEC, provider training)

Organization	Program/Type of activity	Location
Abt Associates, Inc.	Includes SDM in national norms and service delivery protocols	Mali
APROFAM	Integrating SDM & LAM into their IEC activities and their capacity building activities for MOH Traditional Birth Attendants	Guatemala
ACCESS-FP/Jhpiego	Including SDM and LAM in mission-funded training.	Nigeria, Afghanistan
CARE	EMI project trained healthcare workers in CycleBeads and SDM use.	Madagascar
Care	Includes SDM in flip-chart for CBDs and includes SDM in provider trainings	Mali
Catholic Relief Services	Incorporate FAM into the new RH program worldwide	Worldwide
Catholic Relief Services	IRH provided distance and on-site technical support to CRS and MOH to integrate SDM and LAM into FP programs and church-based social service programs reaching about half the country. IRH worked with Timorese staff to design baseline assessment instruments, analyze the assessment findings, and develop implementation and M&E plans. Subsequent work with staff on training and IEC materials development helped create a basis of knowledge, competence, and critical materials to begin FAM activities.	East Timor
Childfund	Integrating FAM into their training activities.	Guatemala
Christian Health Association of Kenya	Including SDM and LAM in facility and community-based family planning programs in 7 facilities.	Kenya
Christian Connections for International Health	Included SDM in survey of member organizations	Worldwide
Christian Connections for International Health	Advocate with member organizations and donors to include FAM in family planning activities.	Worldwide
Christian Children's Fund	Incorporate FAM into the new RH program worldwide	Worldwide
ECSACON	A follow on to the ECSACON conference in August 2012, a training activity hosted by ECSA-Uganda for nurses and midwives from ECSACON took place in January 2013. Interest in integrating SDM into more programs continues. This activity was supported by IRH Rwanda Country representative Marie Mukabatsinda.	Uganda
ECSACON	Another follow on to the ECSACON conference in August 2012, a training activity was part of the agenda in the annual meeting for principal tutors from public, faith-based and private nursing school. Interest in integrating SDM more widely in the method	Zambia

	mix in Zambia continues. A three-hour session was led by ECSACON Zambia chapter head Teresa Sikateyo and IRH Rwanda country representative Marie Mukabatsinda.	
ECSACON	Training of trainers from 10 different countries in east, central and southern Africa on SDM and LAM at the ECSACON conference held in Mauritius, August 2012.	Various Countries
Extending Service Delivery	ESD is using SDM and LAM in Yemen while working with religious leaders in family planning.	Yemen
FHI 360	FHI 360's C Change in Benin provided support for IRH to offer technical assistance on the integration of SDM into direct-to-consumer activities.	Benin
FHI 360	FHI 360 integrated SDM into their work in Northeastern Province in Kenya working with Muslim communities.	Kenya
Food for the Hungry	Food for the Hungry provided support for IRH to offer technical assistance on the integration of FAM into their training, community outreach and data collection instruments in DRC.	DRC and Mozambique
Futures Group International	Includes SDM in branded social marketing campaigns (TV, radio, posters, flyers); includes SDM in tools for medical/pharmaceutical detailers	Uganda
Ghana Health Services	Training of trainers and pilot introduction of SDM into service delivery protocol in select sites	Ghana
IFC Macro (Demographic Health Surveys)	The core questionnaire of the DHS interview has been revised to include the SDM. There is a well-defined probe for it, as well as instructions as to which questions should include it (in countries where SDM is provided), and where in the list of method it should appear.	Various Countries
IntraHealth	Includes SDM in provider training, purchases CycleBeads, prints CycleBeads inserts and SDM job aids; includes LAM and SDM in pre-service curricula developed and for nursing schools	Rwanda
IntraHealth	Includes LAM and SDM in pre-service curricula being developed and piloted for nursing schools	Mali
IntraHealth	Includes SDM in provider training, includes SDM in provider job aids	Senegal
IPPF	IPPF procured CycleBeads for their programs in several countries.	Mauritius and Republic of Kiribati
JSI (Focus Regional Health Project)	JSI integrated SDM into family planning services in USAID-supported regions with technical assistance from IRH.	Ghana
KFW	KFW-Burundi has recently purchased 6000 CycleBeads to support FP efforts. As far as we know, KFW has not make CycleBeads purchases before and as a major procurer of FP methods in different countries, it is an important procurement gain.	Burundi
LifeWind	Small NGO now teaching women about SDM.	Kenya, Haiti
Ministry of Health	MOH is procuring CycleBeads for Liberia.	Liberia
Makerera University	Integrated SDM into regional pre-service trainings.	Uganda

Management Sciences for Health	Including SDM and LAM in programs.	Sudan
Management Sciences for Health	MSH has integrated SDM into their family planning activities.	Malawi
Management Sciences for Health	Including SDM in programs.	Haiti
MIDEGO	Incorporated CycleBeads and SDM into the manual used in the 7 day MPH workshop	Worldwide
Marie Stopes	IRH has begun collaborative work with MSI in several countries to build capacity of service providers in MSI clinics to offer FAM.	Pakistan and Madagascar
Pathfinder International & FHI	IRH supports the introduction of SDM into the ESD project by providing technical input to the research being conducted by FHI as well as technical support to the program introduction of the SDM by ESD.	Kenya
Population Council	IRH staff conducted a TOT for trainers in key FP service organizations. Related work with policy makers helped move forward the revitalization of LAM and introduction of the SDM in public sector family planning services.	Pakistan
Population Council	Population Council expressed interest in integrating IRH's new CycleSmart brochure into programs for youth. CycleSmart uses CycleBeads as a tool to teach young girls about their menstrual cycle and what to expect during puberty with a specially designed and tested brochure.	Burkina Faso
PSI	Includes CycleBeads in social marketing	Worldwide
PSI	They are preparing to introduce SDM/CycleBeads into their product line. Revisions to the insert is underway.	Mozambique
PSI	As of 2009, 75,000 CBs have been distributed by PSI Nigeria. PSI is working with a Christian and a Muslim NGO. CBs are considered part of the core FP work by PSI Nigeria evidenced by using bilateral funds to continue support.	Nigeria
PSI	Including CycleBeads in their socially marketed products.	Madagascar
PSI	Includes SDM in general FP awareness-raising activities, in branded social marketing campaigns (TV, radio) and in work of detailers.	Mali
PSP-One Saathiya Project	FAM training and IEC	India
The Salvation Army (TSA)	TSA integrated SDM into their family planning program in Spring of 2013. IRH supported these efforts by encouraging Major Angela Hachitapika (TSA)'s participation in the ECSACON training session taking place, as well as a donation of 6000 CycleBeads to get their program started.	Zambia
Save the Children	Includes SDM in provider trainings	Mali
Tanzania Ministry of Health	IRH led Standard Days Method® (SDM) training at the Tanzania National Family Planning Conference to participants from the Government Central, Regional and Districts levels, NGOs which included FP implementing Partners and research organizations. While SDM was known by some it was new to others, and of interest to all. Follow-up for next steps was discussed. This	Tanzania

	activity was supported by IRH Rwanda country representative Marie Mukabatsinda.	
Uganda Health Marketing Group	Including CycleBeads (MoonBeads) in their socially marketed products.	Uganda
UNFPA	Working with IRH, PASMO, MOH & Calidad to include IEC materials for all methods including SDM & LAM.	Guatemala
UNFPA	Assisting Ministry of Health in Pakistan to incorporate SDM and LAM. (extent of assistance unknown)	Pakistan
UNHCR	UNHCR purchased CycleBeads for relief work in Kenya with Somali populations.	Kenya
UNICEF	Including LAM services in their programming	Mali
URC	Including SDM and LAM in programs	Guatemala
Urban Health Initiative (UHI)	Gates Foundation is providing support for through the Urban Health Initiative in India for capacity building in LAM.	India
White Ribbon Alliance and Indonesian Midwives Association	Providing training in SDM as a strategy to prevent maternal mortality	Indonesia
World Vision	Including SDM & LAM in their integrated birth spacing project	India
World Vision India	FAM training, MIS, IEC	India (UP)

2009 – 2013 Global partners including FAM in policies & guidelines

- Pakistan incorporated SDM into national guidelines with support from the Population Council.
- SDM is included in new FP guidelines in Albania, supported by ACCESS-FP/JHPIEGO.
- The USAID Contraceptive Security Team published Contraceptive Security: Ready Lessons II, an 8 document series directed to assist contraceptive security champions in their work and calls for commitment to contraceptive security. SDM and LAM are included in Issue 8, “Expanding Contraceptive Choice through Support for Underutilized Methods.”
- The Reproductive Health Supplies Coalition included SDM and CycleBeads in a document bringing attention to new and underutilized methods.
- Tanzania has updated the FAM section of Tanzania’s National Family Planning norms.
- The DHS female core questionnaire has been revised to include instructions for countries who want to include SDM in country surveys.
- SDM and LAM were included in the Spanish version of WHO’s medical eligibility criteria wheel for family planning methods.
- IRH contributed sections of SDM and the Rhythm Method to the FP Training for Clinical Providers, which is an FHI initiative funded by USAID.
- WHO has released an Advisory Note providing guidance on the procurement of CycleBeads. See the note [here](#).
- The *Family Planning: A Global Handbook for Providers* is now available as smartphone app called ACE. This app reflects the latest family planning guidance from the World Health Organization’s *Medical Eligibility Criteria for Contraceptive Use*. FAM is included in the ACE mobile app.
- IRH negotiated with PAHO, UNFPA and the MOH in Guatemala to issue the WHO MEC wheel locally, including both SDM and TwoDay Method .

- The Ministry of Health in Uganda has produced a flipchart for community health workers which includes a page on MoonBeads, the brand name of CycleBeads used in Uganda.
- The mHealth Compendium, Edition one includes both case studies from CycleTel (IRH) and iCycleBeads (Cycle Technologies).
- FHI360 included SDM and LAM in their global guidance handbook, “Facts for Family Planning”.
- CycleTel is being used as a case study in an mhealth 101 e-course funded by USAID. The course is for the USAID GHSL platform. CycleTel was featured in a case study two ways - one, with 3 others: ReMiND, Programme Mwanna, and m4RH. These will be 3-4 pages in length, outlining all the steps of implementation: Plan, design and build, monitor and evaluate, scale-up and sustain. The other way is a specific focus on Design, using CycleTel's information to highlight best practices.

2009 – 2013 Global partners providing financial support for FAM

- USAID missions are providing support for FAM in DRC, Ghana, Guatemala, Mali, Rwanda, India, Bolivia, Malawi (through MSH), Nigeria (through ACCESS-FP/Jhpiego), and East Timor (through Catholic Relief Services).
- UNFPA is providing support for FAM in Guatemala, Senegal and East Timor.
- UNICEF providing support for project in Mali to provide LAM services.
- According to CycleBeads sales, there are a number of other global partners that are providing support for FAM by purchasing CycleBeads—this includes PSI, ICON (IPPF), Life International, Concern Worldwide, Christian Health Associations, and Catholic Relief Services.
- FHI 360’s C Change in Benin provided support for IRH to offer technical assistance on the integration of SDM into direct-to-consumer activities.
- Food for the Hungry provided support for IRH to offer technical assistance on the integration of FAM into their training, community outreach and data collection instruments in DRC.
- FHI360 is providing support for through the Urban Health Initiative in India for capacity building in LAM.
- The World Bank supported a project in Kenya where SDM was one of several methods offered in a community-based program.