

AWARENESS Project Nicaragua Country Report 2003–2007

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The Institute for Reproductive Health, affiliated with Georgetown University in Washington, D.C., is a leading technical resource and learning center committed to developing and increasing the availability of effective, easy-to-use, natural methods for family planning.

The purpose of the AWARENESS Project was to improve contraceptive choices by expanding natural family planning options and developing new strategies and approaches to increase the reproductive health awareness of individuals and communities in developing countries.

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The AWARENESS Project

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Acronyms

AMLAE	Asociación de Mujeres Luisa Amalia Espinoza
DMT	Decision-Making Tool
ECMAC	Strategy for Community Delivery of Contraceptive Supplies
IEC	Information, Education, and Communication
INSS	Nicaraguan Social Security Institute
IRH	Institute for Reproductive Health
JHU/CCP	Johns Hopkins University Center for Communication Programs
KIT	Knowledge Improvement Tool
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Non-governmental Organization
PAHO	Pan American Health Organization
QAP	Quality Assurance Project
RPS	Red de Protección Social
SDM	Standard Days Method [®]
SILAIS	Local Systems of Comprehensive Health Care Delivery
SONIGOB	Nicaraguan Gynecology and Obstetrics Society
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
UPOLI	Universidad Politécnica de Nicaragua
USAID	United States Agency for International Development
WHO	World Health Organization



Country Program Summary

Nicaragua

In 2003, IRH and MSH formed a partnership to support the MOH in the integration of the SDM into public-sector family planning services through the Health Leadership and Management Project. IRH provided technical assistance to MSH/Nicaragua for training key agents, an initial donation of CycleBeads and IEC materials, and support for a local strategy to ensure SDM sustainability in the public sector and NGOs.

In 2004, IRH became part of USAID/Nicaragua's Reproductive Health and HIV/AIDS Program, working with the Panamerican Social Marketing Organization (PASMO/PSI), DELIVER (John Snow), the Proyecto Acción SIDA de Centroamerica (PASCA), Quality Assurance Project (URC), and the Futures Group. This joint effort made it possible to include the SDM in the agenda of these partners.

As requested by the MOH, IRH implemented a demonstration study in 7 of the 17 comprehensive health service delivery areas (SILAIS) in the country. Study results helped improve training and service delivery protocols and tools. PAHO/WHO also conducted a study to validate the Decision-Making Tool for Family Planning, a family planning counseling flipchart that includes the SDM. One hundred providers from 50 clinics participated, representing ProFamilia and all 17 MOH SILAIS. Results demonstrated that the SDM could easily be incorporated into training programs for all family planning methods.

From 2004 to 2006, IRH and in-country partners trained over 1,000 service providers and 250 facilitators from 336 public-health health facilities on the SDM and provided follow-up support. In 2004, at the request of the NICASALUD NGO network, IRH trained key agents of its affiliates interested in introducing the SDM into their programs, certifying 27 SDM facilitators and eventually training 561 providers in six NGO clinics. USAID, PAHO/WHO, UNFPA and CAs supported all SDM training activities. SDM services were first provided in March 2004.

The SDM is included in the family planning guidelines and in the national strategic plan to guarantee contraceptive availability. The DELIVER Project, in coordination with the MOH and IRH, incorporated the SDM into the national logistics system and the list of basic supplies. Despite these advances, there is no commitment to purchase additional CycleBeads. The SDM is not currently included in MOH statistical systems, but will be when the next review takes place in 2009.

Limited resources and priority shifts have made it difficult to attain specific commitments to provide financial support for the SDM or to assume the lead in training and dissemination activities. A useful next step would be to conduct a workshop with key stakeholders to review achievements and plan next steps, including choosing a lead SDM agency in Nicaragua. A national workshop with nursing and medical school officials to consider and plan inclusion of the SDM in curricula and research for postgraduate programs would also be useful.

I. Introduction

A priority of the 2004–2015 Nicaraguan National Health Plan is to improve the population’s access to health services. For cultural, geographic, and economic reasons, family planning services are still unavailable to many Nicaraguans. According to the 2001 Demographic and Health Survey, 45% of women in union were using a family planning method at the time of the survey. In response to unmet need and as part of its technical assistance to Nicaragua’s Ministry of Health (MOH), Management Sciences for Health (MSH) decided to integrate the SDM into the basket of services offered to the public sector through the Health Leadership and Management Project. MSH sought to increase access to family planning, expand method choice, and contribute to national health goals.



Source: CIA World Factbook 2008

The government institutions and cooperating agencies that shared the goal of improving the quality of health services in Nicaragua developed a plan to achieve SDM integration and sustainability. However, when MSH’s technical assistance to the MOH family planning program ended in July 2004, public and private institutions had not fully completed the SDM integration process at the local level. Consequently, IRH hired a consultant from 2003–2006 to support further integration of the SDM.

II. Objectives And Strategy

In 2003, IRH and MSH formed a partnership to support the MOH in incorporating the SDM into its family planning services. The integration and sustainability plan focused on five strategic areas: training, commodities, services, research, and advocacy.

The Strategy for Community Delivery of Contraceptive Supplies in communities with poor access (ECMAC)* guided the SDM initiative. This national strategy aimed to increase access to services in areas with low coverage relative to demand. IRH and MSH presented the SDM to MOH officials as a viable option to increase contraceptive options and improve overall family planning services in the country. The MOH accepted the proposal for implementation, with the condition that the team first carry out a demonstration study.

One of the project objectives was to increase the quality and availability of family planning. Part of IRH’s mission is to support governments and nongovernmental organizations (NGOs) in the incorporation of fertility awareness-based methods into existing programs. IRH, therefore, provided technical assistance to MSH in Nicaragua for training; an initial donation of CycleBeads® and information, education, and communication (IEC) materials; and design support for a local strategy to ensure SDM sustainability in the public sector and NGO programs.

* ECMAC: MOH policy for the delivery of contraceptive methods in communities with poor access. Responds to an indicator in the National Plan for Poverty Reduction and the Goals for the Millennium.

III. Activities and Accomplishments

In 2004 IRH became part of USAID Nicaragua's Reproductive Health and HIV/AIDS Program, the purpose of which was to achieve more comprehensive action in the areas of reproductive health and HIV/AIDS. IRH and MSH presented the workplan for integrating the SDM in Nicaragua to a team of partners comprised of the Pan American Social Marketing Organization, the DELIVER Project, the Central America HIV/AIDS Prevention Project, the Quality Assurance Project (QAP), and the Constella Futures Group. This joint effort made it possible for the SDM to be included in the agenda of these partners and for them to carry out reproductive health and family planning activities that included SDM. Other important partners joined the team to work with the SDM, including the United Nations Population Fund (UNFPA), which provided technical and financial assistance for supplies and training; the Pan American Health Organization/World Health Organization (PAHO/WHO); and NICASALUD, a Nicaraguan umbrella group of health NGOs.

Once MOH officials and USAID approved the SDM proposal, the team presented it to stakeholders at the annual meeting of the Ministry's AIM (Comprehensive Health Care for Women) Project and to representatives of all 17 SILAIS (government health administration areas) to validate it operationally and set forth a workplan. During the first quarter of 2004, IRH signed agreements with central and local governments, and prepared plans to provide the SDM and to register users for the demonstration study.

A. Research

The project carried out two SDM studies. The first was a demonstration study carried out in seven SILAIS, at the request of the MOH, to determine women's reasons for using the SDM. This study also explored the profile of SDM users and the feasibility of incorporating the SDM into family planning services offered by the public sector. The MOH required the study before making a decision to officially incorporate the SDM into its programs. The second study was a PAHO/WHO initiative to validate the Decision-Making Tool (DMT) for Family Planning—known in Nicaragua as the Family Planning Methods Flipchart—which includes the SDM. Seventeen MOH SILAIS and Profamilia, the local affiliate of the International Planned Parenthood Association, participated in the study.

Findings from these studies demonstrated that it was viable to incorporate the SDM into public-sector and NGO programs because the SDM was accepted by users and providers, was low cost, and did not require re-supply. The studies also showed that users found the SDM easy to learn and providers found it easy to teach. A large age of providers found that, in addition to increasing family planning options, offering the SDM facilitated discussions with clients during counseling about sexuality, prevention of sexually transmitted infections (STIs), and couple communication.

User data from the demonstration study showed that providing SDM information and materials encouraged couple discussion on fertility and sexual issues. Some 90% of women who chose the method discussed with their partners how to protect themselves on fertile days. In addition, 50% of women said their partners agreed to use condoms, 45% to abstain, and the rest planned to use both strategies to manage fertile days. Integrating the SDM into services also helped programs to

reach men; 33% of male users learned about the SDM through male providers and community leaders.

i. SDM demonstration study

The SDM demonstration study started in March 2004 in seven municipalities. IRH supported the design of the study and instruments, data collection, and the recruitment and follow-up of users and their partners. The research team and service providers validated the study instruments.

Participants provided basic information about socio-demographic characteristics and why they had chosen the SDM. SDM users were registered using a form specifically designed for the study and followed for six months to determine if they were still using the method correctly and reasons for discontinuation for those who had stopped. Each received CycleBeads and a personal calendar. Providers scheduled users for a follow-up visit at the end of the first cycle of use, as required by the method protocol. However, not all users returned for their follow-up visit; in some cases, the study team made home visits to obtain user data. Most users found the method easy to learn and explain to their partners, and used it correctly.

Results showed that 343 users chose the SDM from the planning methods available. By June 2005, when activities concluded, 261 users remained active, 56 had dropped out, and 26 had become pregnant. (See Table 1.) MOH health centers confirmed all pregnancies.

MOH and IRH staff visited participating clinics and health posts and applied the Knowledge Improvement Tool (KIT)—a provider knowledge assessment tool developed by IRH—to determine provider knowledge and competency. IRH staff also reviewed medical records and interviewed providers to obtain information about correct use among users. There were ten reported cases of pregnancy where staff had not been formally trained and failed to deliver the method appropriately by inadequately applying the selection criteria. The data indicate that the pregnancy rate for correct use of the method was 1%, lower than the 5% expected for the SDM.

Table 1. Pregnancies Reported Between March 2004 and March 2005 (n=343)

SILAIS	Method Failure	Incorrect Use User Failure	Incorrect Use Provider Failure	Total
Carazo	2	3	4	9
Chinandega	1	1	2	4
Boaco	0	1	0	1
Madriz	0	1	0	1
Matagalpa	0	3	2	5
Chontales	0	1	0	1
Granada	0	3	2	5
TOTAL	3	13	10	26

The MOH initially wanted to find out users’ reasons for choosing the SDM and their profile in order to assess the feasibility of offering the method widely in its programs. Most users chose the

SDM because they had experienced adverse effects with other methods. One-third of users selected the SDM because they wanted to use a natural family planning method. Other reasons for choosing the SDM were religion and effectiveness.

Table 2. Reasons for Choosing the SDM (n=261)

Reason	Number of Acceptors	Percentage of Acceptors
No effect on health	129	49.4
Preferred natural method	74	28.4
Religion	8	3.1
Effective/Previous method failed	9	3.4
Did not find method they were looking for	7	2.7
Missing*	34	13
TOTAL	261	100

*34 cases without information

The SDM user profile is not different from that of other methods. Most users were 20–35 years of age, had primary school-level education, and were equally distributed in urban and rural areas.

Service providers were motivated to offer the SDM for three primary reasons: 1) its contribution to expanding the method mix, 2) user demand, and 3) lack of side effects. Recognizing the need for partner support, providers counseled women on how to communicate with their partners to avoid unprotected sexual intercourse on fertile days and STIs.

Study results contributed to improving training and service delivery protocols and tools. The team restructured training workshops to emphasize eligibility criteria and couple communication. Results also showed that, even though the basics of the SDM were easy to learn, providers had weak counseling skills, an issue also addressed in training.

In April 2005, the project team organized a meeting with cooperating agencies, MOH officials, community organizations, and NGOs to discuss progress made and next steps for sustainable SDM integration. Participants concluded that continuing training activities and securing supplies of CycleBeads were critical to accomplish this goal. However, despite interest in the SDM, there were no clear commitments from the participants to fund and distribute CycleBeads or take the lead in training and promotional activities.

ii. Validation study of the Family Planning Methods Flipchart

In 2004, PAHO/WHO invited Nicaragua to participate in a validation study of the “Decision-Making Tool (DMT) for Family Planning Clients and Providers”. The DMT flipchart, developed by WHO and the Johns Hopkins University Center for Communication Programs (JHU/CCP), seeks to improve the quality of counseling by 1) promoting a client’s informed choice and participation in family planning service delivery, 2) enabling providers to apply evidence-based best practices in the client-provider interaction, and 3) providing the technical information necessary for optimal delivery of contraceptive methods. The study assessed the usefulness and effectiveness of the DMT to improve client-provider communication and the quality of

information offered during family planning counseling sessions. One hundred service providers from 50 clinics participated in the study. Since the SDM had been included in the DMT, IRH was interested in exploring the impact of the DMT in delivery of the method.

The study included the following questions:

- Do training and the use of the DMT have an impact on the quality of counseling?
- Are clients more satisfied with counseling using the DMT?
- Does the DMT affect behavior, including method continuation?

The study compared videotaped counseling sessions led by the same providers before and after they were trained to use the flipchart. Researchers collected data at two points: a baseline before the intervention began, and a second round four months after providers were trained to use the DMT flipchart. Client exit interviews were also compared between the two points in time.

To test the influence of the flipchart on contraceptive behavior, the study compared continuation rates at intervention clinics with rates at control clinics. One month after provider training, clients were enrolled in this arm of the study. The research team collected continuation data seven to eight months later among users of the injectable and oral contraceptives, the methods that predominate in Nicaragua.

Results demonstrated that the SDM could easily be incorporated into training programs covering all contraceptive methods, if service providers are well trained. WHO and JHU/CCP used study findings to produce a guide for adapting the flipchart to specific country settings. The Nicaraguan MOH also used the findings to revise and refine the flipchart and the associated training of providers.

B. Building awareness of and support for the SDM

The team identified the need to increase awareness of the range of family planning methods, especially a new method like the SDM, prior to implementing the DMT validation study. To ensure the necessary number of users of all family planning methods, IRH supported the MOH in disseminating informational messages in study areas using radio, posters, and banners. A general message, “Ask Me about Family Planning”, was used to encourage women to request information about all methods, including the SDM. The MOH also developed promotional materials to motivate service providers and increase the amount of information given to users.

IRH staff participated in the National Guidelines for Family Planning review due to interest in the SDM in Nicaragua. Based on an appraisal of SDM research, the review team decided to include the SDM in the National Guidelines. The National Contraceptive Security Committee also included the SDM in its strategic plan to guarantee the availability of contraceptive methods in the country after USAID procurement funding ends. In addition, the DELIVER Project, in coordination with the MOH and IRH, included the SDM in the Consolidated Supply and Logistics System and on the national list of basic supplies.

Educational institutions and professional associations also expressed interest in the SDM. At their request, the project provided information and training to the Nicaraguan Gynecology and Obstetrics Society (SONIGOB), nursing schools, the Chamber of Partners of Provisional Medical Enterprises—healthcare providers for the Nicaraguan Social Security Institute (INSS),

and Brigadistas del Movimiento Comunitario. As a result, the SDM is now included in the technical guidelines for the INSS family planning service.

It is important to highlight that IRH, in spite of the political unrest and economic problems in Nicaragua during this period, continued its efforts to support the MOH and NGOs in their work to improve the quality of reproductive health services.

C. Developing the capacity of local organizations

MOH decision-makers proposed that the SDM integration process be carried out in two phases: 1) conducting and documenting a small-scale demonstration project in accessible municipalities; and 2) extending the service to all SILAIS units in conjunction with IEC activities to generate broader use of family planning methods, including the SDM. The proposed strategy included training activities ranging from sensitization meetings with MOH decision-makers to workshops on offering the method for providers.

i. SDM training

To introduce SDM services, MSH and the MOH prepared a training plan based on the use of key MOH facilitators, due to their roles as educators and supervisors. These facilitators replicated the SDM training at the local level and distributed initial supplies to begin offering services. These facilitators were also responsible for carrying out follow-up training activities.

In November 2003, the project certified key facilitators in seven SILAIS as SDM trainers upon completion of a two-day workshop. The training covered all aspects of SDM service delivery, including managing sexuality issues and improving couple communication. Workshop evaluations showed assimilation of 90% of the key content, with the weakest aspects related to selection criteria and counseling on sex and sexuality. The facilitators made a commitment to train in cascades and coordinate the demonstration study activities.

In February 2004, the NICASALUD network requested that IRH train key agents of its affiliated NGOs interested in introducing the SDM into their reproductive health programs. IRH conducted a two-day workshop and representatives from CARITAS and NICASALUD participated, at the request of USAID/Nicaragua. After this training, the project certified 27 SDM facilitators and provided them with support materials and CycleBeads to replicate the training at other levels.

In addition, MSH and UNFPA personnel, previously trained on the SDM, helped the MOH develop a training workshop for service providers on how to offer the SDM and, in initial workshops, how to document information for the demonstration study. The project trained MOH staff over a period of two years (2004–2006), and IRH staff supported them through follow-up visits. According to data collected by IRH, 1,066 service providers and 242 facilitators were trained on the SDM at all 336 health facilities in the geographic areas covered by the project. Tables 3 and 4 below give details on MOH staff trained.

**Table 3. MOH Staff Trained on the SDM per SILAIS
January 2004 Through May 2006**

SILAIS/NGO	Trained Providers	Trained Facilitators	Number of Facilities
Rivas	172	32	35
Granada	163	24	22
Masaya	47	10	24
Carazo	97	12	29
Managua	10	4	1
León	60	11	31
Chinandega	162	34	44
Matagalpa	62	12	35
Jinotega	91	22	15
Estelí	25	20	19
Nueva Segovia	34	1	14
Madriz	20	14	26
Boaco	84	27	24
Chontales	39	19	17
Total	1,066	242	336

**Table 4. MOH Staff Trained on the SDM
January 2004 Through May 2006**

Provider Type	Female	Male	Total
Medical Personnel	294	198	492
Nursing Personnel	532	75	607
Nursing Assistants	322	47	369
Other Professionals	35	3	38
Health Technicians	17	7	24
Community Personnel	53	17	70
Community Volunteer Workers	310	55	365
Total	1,563	402	1,965

Training activities gradually expanded to additional SILAIS and NGOs. During 2004–2005, the IRH team provided initial training workshops to ProFamilia, Brigadistas del Movimiento Comunal, Project HOPE, and Catholic Relief Services staff. ProFamilia also trained its staff on the SDM as part of the validation study of the DMT. PAHO/WHO supported training for the Brigadistas del Movimiento Comunal to increase the information and service coverage in indigenous communities. Table 5 provides detail about the number of NGO providers that received training.

To ensure follow-up and expansion of SDM trainings, the MOH implemented the Award for Knowledge[†] strategy with the support of USAID and QAP. The overall goal of this strategy is to encourage staff to provide services according to accepted norms and protocols. The strategy functions as a knowledge contest where the best qualified staff receive both a personal award and one for the health establishment where they are employed. The SDM was incorporated into the

[†] The Award for Knowledge is a self-study strategy on a specific topic. Representatives of each facility conduct the evaluation, using a series of questions or demonstrations to verify assimilation and retention of topic information.

program as a self-study topic using service provider materials and tools developed by IRH. The experience with the SDM was the first of its kind at the primary level of care in Nicaragua. According to data collected by IRH, participants achieved acceptable levels of knowledge to provide quality services. Nine MOH SILAIS participated in the Award for Knowledge, an initiative supported by ProFamilia, USAID, NICASALUD, and QAP.

Table 5. NGO Staff Trained on the SDM (2005–2006)

Institution	Service Providers	Facilitators
PROMUJER	17	1
PROFAMILIA	2	2
NICASALUD	0	37
MIFAMILIA (RPS)	22	2
SONIGOB	0	24
POLISAL	0	17
DELIVER	0	1
QAP	0	1
Trinidad Nursing School	0	2
IXCHEN	0	2
AMLAE	0	1
UPOLI	85	3
Brigadistas Comunitarios	435	0
Total	561	93

USAID, its cooperating agencies, PAHO/WHO, and UNFPA all supported various SDM training activities, including the purchase of training materials and CycleBeads and training logistics support, including food and transportation for trainees.

ii. SDM service implementation

SDM service provision began in March 2004. Once staff were trained, health facilities gradually introduced the services. The project also trained volunteers and community promoters both to increase awareness of the method in the community and to refer potential users appropriately.

Health providers received a package of tools that included a provider job aid, a calendar, and CycleBeads to provide counseling. Providers participating in the validation study used the DMT, which contained similar information. This demonstrated that the SDM could be offered by providers using either the DMT or with the support tools developed by IRH. By June 2006, 336 of 913 participating health facilities (37%) were offering the SDM. (See Table 6 for details.)

Table 6. Health Facilities Offering the SDM per SILAIS, June 2006

MOH SILAIS	Number of Health Centers Offering the SDM	Total Number of Health Centers	Percentage of Health Centers offering the SDM
Rivas	35	42	83
Granada	22	32	69
Masaya	24	41	58
Carazo	29	31	93
León	31	100	31
Chinandega	44	96	46
Matagalpa	35	103	34
Jinotega	15	62	24
Estela	19	54	35
Nueva Segovia	14	71	20
Madriz	26	38	68
Boaco	24	38	63
Chontales	17	90	19
Managua	1	115	1
TOTAL	336	913	37

Source: MOH

Despite having received an initial donation of CycleBeads and provider job aids, NICASALUD and CARITAS did not have a high number of users. ProMujer and ProFamilia were able to recruit more users and thus played a key role in SDM expansion. All four health units belonging to ProMujer offer the SDM, as well as two of the 17 ProFamilia health units.

Given the large number of staff trained in each SILAIS and the need to ensure that the SDM was actually integrated into services after delivery, IRH hired a consultant to carry out training follow-up visits with providers and users for a period of six months. The consultant carried out simulated counseling sessions with providers using the KIT to identify areas needing reinforcement.

IRH staff, local MOH monitors, and the SILAIS facilitators trained by the MOH at the beginning of the project also carried out site visits. During the initial training workshop, SDM facilitators developed a follow-up module based on the KIT. Some 300 monitoring visits were conducted with 234 providers, although none took place in the Nicaraguan Caribbean Coast regions because the materials needed to be adapted to native languages and have the approval of local authorities. This region was not included in project activities.

D. Incorporating the SDM into reporting systems

Since the SDM is not officially included in MOH statistical records and forms, participants in the demonstration study were registered using a form developed for this purpose. However, in some cases, providers documented users as margin notes in the daily user log, activities report, or makeshift registries created by clinic staff. To increase accurate reporting, IRH advocated to have the SDM included in official MOH statistical records, which will occur when the next scheduled revision takes place in 2009.

E. Generating commitment of resources to the SDM by governments, NGOs, or donor agencies

IRH's work in Nicaragua has demonstrated much interest in the SDM within the MOH, NGOs, professional medical associations, and universities. However, it has been challenging to obtain specific commitments from these organizations to support activities and assume the lead in training and dissemination. Due to limited resources and priority shifts in the region, IRH decided in 2006 to close its field office and scale back activities. In late 2006, IRH conducted a series of interviews with ProFamilia and NICASALUD to determine capacity and interest in continuing expansion of the SDM with limited support from IRH. Although interest exists, there is a need to further explore sustainable strategies that will enable local organizations to assume the responsibility for integration activities with minimal IRH support.

F. Incorporating the SDM into the logistics system

Although the SDM does not require re-supply, users receive CycleBeads when they choose the method to help them identify their fertile days. CycleBeads are low in cost: when purchased with USAID funds, they are less than \$1 per set. When it began activities in Nicaragua, IRH donated a supply of 1,000 CycleBeads, including an instruction insert and user calendar, for use in the initial trainings of service providers. IRH also provided 1,000 individual packages of service provider tools to assist with counseling practice. UNFPA—through arrangements made by MSH—provided funds to the MOH for the acquisition of 1,000 additional CycleBeads used to provide the SDM in the SILAIS that implemented the demonstration study. The Directorate for Comprehensive Health Care Delivery to Women distributed these CycleBeads.

IRH also donated CycleBeads to the DELIVER Project for inclusion in the national commodities system. However, there is no commitment to purchase additional units.

G. Summary of experience of the SDM introduction and expansion

Currently, the SDM is offered in 336 MOH facilities (37%) and in six NGO clinics. Because the SDM is not disaggregated in the Ministry's management information system, it is not possible to accurately determine how many users there are or how many trained providers are actually offering the method. According to the MOH user registry for the demonstration study, 343 women had chosen the SDM, out of which 261 were still active users, 26 became pregnant due to incorrect method use, and 3 (1%) reported pregnancies due to method failure. Data collected during the demonstration study shows that in Nicaragua, the pregnancy rate with correct method use is lower than that scientifically defined for the SDM (5%). The reasons for using the SDM are the same as those cited by users of other family planning methods. Two-thirds of users chose the SDM because of adverse effects experienced while using a previous method and one-third because it is natural. Most users were not using any other family planning method at the time they opted to use the SDM.

IV. Challenges

Despite acceptance and support for the SDM, political and social constraints such as a medical and health sector strike paralyzed training activities for six months. This prevented the timely

implementation of many programmed activities. Other factors inhibiting programming stemmed from structural problems that follow.

- Insufficient staff are assigned to family planning programs, and high turnover rates disrupt service provision.
- The service model did not include monitoring and supervision as systematic service activities.
- There is low motivation among health staff due to low salaries and socio-economic difficulties in the country.
- Limited information is available about the effectiveness of fertility awareness-based methods and latent demand among populations in Nicaragua.
- Uncertainty about project and foreign aid for NGO programs causes lack of motivation and social commitment.
- Changes in government administration affect employment stability at the program director and supervisor levels.

V. Lessons Learned

Perhaps the most important lesson learned from IRH's experience in Nicaragua is that the SDM can be incorporated into existing family planning services. Even though it requires the same amount of time to train service providers on the SDM as it does for other family planning methods, the SDM's supporting tools and training materials are low cost, especially when purchased in large quantities.

Furthermore, the experience in Nicaragua confirmed the interest of different organizations in working with the SDM. Medical professional associations such as the gynecologists' association, nurses' associations, church programs, training institutions, and women's groups were among the organizations that participated in trainings and began to offer the method.

Forging alliances with NGOs, as in the case of ProMujer and NICASALUD, helped broaden the base of support for the SDM. However, because these are relatively new alliances, close collaboration and ongoing support is necessary to ensure quality of products and service delivery.

In the Nicaraguan context, the introduction of a new family planning method, especially one that must involve the partner, requires time and ongoing support to ensure acceptance and high service standards among providers. Introducing the SDM required dissemination, training, and promotion, as for any other family planning method, to increase awareness and demand among clients.

This experience demonstrated that the initial training and service implementation need to be consolidated with follow-up and support for service providers and health systems. In clinics where routine follow-up was not possible, staff were less motivated to continue training and service delivery activities at the local level.

V. Future Plans and Recommendations

A. Family Planning Service Organizations

Research and experience from a number of countries show that the SDM can effectively address unmet need for family planning. In Nicaragua, interested institutions, especially the MOH, should consider the benefits of consolidating its incorporation into national programming as a low-cost and easy-to-implement option.

The Ministry of Health

The MOH is in the best position to support SDM expansion in Nicaragua. The next step could be to conduct a workshop with MOH decision-making officials and donor agency representatives to take stock of what has been achieved and plan next steps.

Critical for SDM sustainability, IRH established strategic alliances with NGOs and other health agencies to conduct staff training and service follow-up. NGOs such as ProFamilia, ProMujer, and Ixchen—a local consulting group well-known for its work with the MOH—and foreign cooperating agencies could help streamline mechanisms to institutionalize the SDM fully.

The Directorate for Comprehensive Health Care Delivery to Women should continue efforts to incorporate the SDM into official statistical records. Meanwhile, authorities need to define and develop a strategy to incorporate SDM user data into the system. In addition, the Ministry should choose an agency to follow up the process started by the DELIVER Project to include the SDM in the list of Ensured Availability of Contraceptive Supplies.

Departmental levels: The SILAIS that received training and technical assistance have enough staff to continue providing the SDM. Until CycleBeads are incorporated into the official logistics and purchasing system, an additional donation will be required. In Nicaragua, the strong alliance of donor agencies, institutions, and projects working with sexual and reproductive health, led by USAID and other donor agencies at the SILAIS level, could serve as a vehicle to support procurement agreements.

CycleBeads distribution: The MOH and donor agencies could choose an interested agency to manage this activity in Nicaragua and the region. Experiences on social marketing of CycleBeads in different countries should be considered.

Family Planning Program: IEC activities should be developed to increase awareness of available family planning methods, including the SDM, and increase demand.

The Social Security Institute

The SDM could represent an opportunity for the INSS to meet the need of a sector of the population that demands greater options in family planning services. INSS staff will require training and technical assistance to incorporate the SDM into services. The INSS could establish a collaborative working relationship with IRH and the MOH through a memorandum of understanding to continue training their staff, purchase CycleBeads, or plan the use of donated CycleBeads to support gradual implementation of SDM services.

NGOs

The SDM should be of special interest to all organizations working with women's rights and services as an opportunity to teach women about fertility, their bodies, and communication with their partners as tools for decisionmaking. (Women should be pre-screened for their ability to negotiate the fertile days.) The SDM can also increase effective male participation in family planning. This interest could lead to carrying out studies that show changes in couple's relationships and a women's ability to negotiate on sexual intercourse and family planning issues through SDM implementation.

B. Human Resources

An essential component for sustainability involves incorporating the SDM into the curricula of nursing and medical educational institutions. The successful experiences IRH has developed in several Latin American countries can serve as models for these institutions. A national workshop with nursing and medical school directors and deans to discuss strategies to include the SDM in the curricula and research plans for master and doctoral programs would be useful. In addition, experiences developed and implemented in other countries in the region could be made available for further study and use.

C. Health Professional Associations and the Media

The SDM could also be an important source of new research on fertility and its dynamics for professional associations such as the Nicaraguan Gynecology and Obstetrics Society (SONIGOB). SONIGOB can contribute both to the professional development of its members as well as health policies in the country. IRH makes available to such organizations its technical assistance, materials, and publications to increase understanding of the SDM and other fertility awareness-based methods and their potential contribution to the National Health Plan's objective of increasing access to health services.