Evaluation of the Awareness Project

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Abbreviations

ABPF	Association Béninoise pour la Promotion de la Famille
ASPEFBOST	Peruvian Federation of Schools of Midwifery
ADRA	Adventist Development and Relief Agency
AED	Academy for Educational Development
APHA	American Public Health Association
ARC	American Red Cross
ASHONPLAFA	Honduran Association of Family Planning
CA	Cooperating Agency
CB	CycleBeads
CBD	Community-based Distribution
CEDPA	Centre for Development and Population Activities
CEMOPLAF	Centro Médico de Orientación y Planificación Familiar
CEVIFA	Center for Family Life Education
CEU	Continuing Education Unit
COCEMOB	Central American Commission of Billings Method Providers
COP	Peruvian Association of Midwives
CPR	Contraceptive Prevalence Rate
CRS	Catholic Relief Services
CTU	Contraceptive technology update
CYP	Couple Years of Protection
DGI	Development Group, Inc.
DHS	Demographic and Health Survey
DMT	Decision Making Tool
DRC	Democratic Republic Congo
EC	Emergency contraception
ESD	Extending Service Delivery
FAB	Fertility Awareness-based
FAM	Fertility Awareness Methods
FBO	Faith-based Organization
FGI	The Futures Group International
FIGO	Federación Internacional de Ginecología y Obstetricia
FLASOG	Federación Latinoamericana de Sociedades de Obstetricia y Ginecología
GO	Governmental Organization
GOI	Government of India
GU	Georgetown University
HIPNET	Health Information and Publications Network
IBP	Implementing Best Practices
ICDS	Integrated Child Development Services
ICPD	International Conference on Population and Development
IEC	Information/Education/Communication
IPPF	International Planned Parenthood Federation
IR	Intermediate Result
IRB	Institutional Review Board
IRH	Institute for Reproductive Health
IRH/P	Institute for Reproductive Health/Philippines
ISR	Instituto de Salud Reproductiva
JHS	Jharkhand Health Society
JHU/CCP	Johns Hopkins University Center for Communication Programs
JSI	John Snow International

KIT	Knowledge Improvement Tool
LAM	Lactational Amenorrhea Method
LTFU	Long Term Follow-up
M&E	Monitoring and Evaluation
MIS	Management and Information Systems
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSH	Management Sciences for Health
NFP	Natural Family Planning
NGO	Non-governmental Organization
OC	Oral Contraceptive
OKADES/KAYA	Organisation Catholique pour le Développement Economique et Social
OPA	Office of Population Affairs
OPRH	Office of Population and Reproductive Health
OR	Operations Research
PAA	Population Association of America
PATH	Program for Appropriate Technology in Health
PC	Population Council
PCI	Project Concern International
PHN	Population Health/Nutrition
PNSR	National Reproductive Health Program
PSI	Population Services International
PSR/AF	Réseau Population et Santé de la Reproduction en Afrique Francophone
PVO	Private Voluntary Organization
RFA	Request for Applications
RTU	Research and Technology Utilization
SAGO	Francophone African Society of Obstetrics and Gynecology
SARA	Support for Analysis and Research in Africa
SDI	Service Delivery Improvement
SDM	Standard Days Method
SFH	Society for Family Health
SO	Strategic Objective
SOTA	State-of-the-art
TA	Technical Assistance
TDM	Two-Day Method
TOT	Training of Trainers
UNFPA	United Nations Population Fund
UP	Uttar Pradesh, Indian State
URC	University Research Corporation
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
ZANA	Zanzibar Nurses Association

Executive Summary

The United States Agency for International Development (USAID) Office of Population has supported the Georgetown University Institute for Reproductive Health since 1985, through a series of cooperative agreements. This support is indication that USAID promotes availability and access to the widest possible number of modern family planning methods for women and couples. The current project, AWARENESS, was authorized July 7, 1997 and will end May 31, 2007. Its main objectives were to:

1. Develop, test and make simple new NFP methods available
2. Improve NFP service delivery systems, increasing GO and NGO capacity
3. Mainstream NFP into integrated reproductive health and other services utilizing operations research and broad collaboration with service delivery and donor organizations; in addition, increase male involvement and couple communication

This evaluation was conducted in February and March 2006 by a three-consultant team; evaluation activities included briefings, interviews, document reviews and country visits to Peru, India and Rwanda. The evaluation team's SOW was to: (1) assess project performance, (2) assess impact of its research findings and newly developed methods on family planning and reproductive health programs worldwide and (3) provide USAID with guidance on a possible follow-on project design and funding.

Findings:

IRH has, to a great extent, fulfilled its objectives. IRH's accomplishments in advancing the project agenda in a short time with a small staff have been recognized as above expectations. IRH has established global leadership on fertility-based awareness methods (FAM) and is universally well regarded and respected. However, significant efforts are needed to fully integrate and mainstream FAM into existing FP programs and prove that up-scaling to large populations can be achieved.

The evaluation showed that IRH has:

- Developed an efficacious, simple, attractive, client-friendly contraceptive method, the Standard Days Method (SDM), and related tools, including the innovative CycleBeads (CB). It has conducted operations research to understand acceptability, up-take and proper use, and to test different training strategies. A second method, the TwoDay Method (TDM), has also been proven efficacious but research on program integration lags behind that of SDM;
- Produced and distributed a large number of well designed and user friendly materials for training, service delivery and program guidance;
- Demonstrated concern for quality in all its work including FAM research, dissemination and utilization of research results, and materials development;
- Proactively collaborated with a wide range of research and other organizations, exhibiting responsiveness and professionalism in providing technical assistance;
- Earned the reputation as a serious research organization, recognized for integrity;
- Been very entrepreneurial;

- Addressed a spectrum of scientific, clinical, operational and policy issues in testing, piloting and introducing SDM;
- Maintained dialogue and achieved acceptance from a broad range of actors involved in FAM from across the spectrum: leading international agencies, policy and decision-making bodies, agencies providing broad FP services as well as traditional NFP groups.

IRH has strong credibility as a research organization resulting from the rigor with which research has been conducted. It has systematically studied SDM and, to a lesser extent, TDM to understand efficacy and programmatic elements. Presently, IRH is testing SDM service scale-up strategies in selected geographical areas in Rwanda, India and Peru under controlled circumstances and measuring the impact of these actions on method awareness, demand and proper use; results should be available by the end of 2006.

SDM and TDM have been highlighted as modern family planning methods in key scientific journals and international guidance documents by WHO and other leading resources. (See Appendix 8 for a list of IRH publications). In addition, IRH has been featured in popular press in the US and abroad, increasing method recognition by the general population.

IRH has been very active in several of USAID's global leadership priorities: MAQ, IBP, and Repositioning Family Planning, maintaining its presence and providing updated information to a host of CAs, other important agencies such as WHO, and USAID staff. The Repositioning Family Planning initiative offers particular promise going forward, for example in Madagascar, as IRH's work relates very directly to repositioning FAM as more than NFP. Given that men's support is essential for FAM use and that there are other gender dimensions to explore (possible changes in condom use or reputation, other effects on couple's sexual health behavior) or expand (men as community workers providers), we recommend that IRH reconnect with the gender working group to share information about its findings and to leverage collaboration and possibly funding.

SDM has proven to have clear advantages to programs and to users, and could play an important role in addressing unmet need especially in some settings that are challenging for other modern methods: it has been shown attractive to new FP users and may serve as a bridge to other modern methods; it does not require re-supply for users and thus is not affected by contraceptive stock-outs; it gets men's interest and participation in FP and promotes couple dialogue; it can enhance the image of FP.

However, important barriers remain for the introduction and expansion of SDM:

- Uninformed perceptions of the method as ineffective, labor-intensive, or tied to religious proponents have caused skepticism or opposition from some potential partners;
- Although easy to teach providers and clients, and for women to practice, it is not necessarily simple to introduce into ongoing FP programs without intensive TA;
- It is almost completely dependent on the availability of CycleBeads, which are perceived by some as expensive although they have a very low annualized cost when compared to pills, injectables and condoms;
- Neither USAID nor UNFPA has included CycleBeads in their commodity lists making acquisition difficult for MOHs and other health agencies.

The success of the SDM has led to increasing demand for IRH technical assistance by USAID Missions, Ministries of Health, and the private sector (commercial, NGOs, FBOs, etc.) wishing to introduce the method. IRH has introduced SDM in 25 countries with varying commitment of resources. Country selection has largely been opportunistic, taking advantage of interest wherever it is found. In the future, we feel that in order to ensure FAM sustainability, IRH has to be more strategic and limited in its country and partner selection. As the SDM becomes more familiar to programs, skepticism of its effectiveness and role in increasing CPR is likely to decrease, and with the recent development of simple programmatic guidelines, the amount of TA and resources needed to introduce the SDM will decrease. Also, as current programs end and new ones start, if the SDM is included in the work plan and budget from a program's inception, marginal costs can be expected to go down significantly.

IRH estimates there are 10,000 trained providers, 5,000 promoters and 2,000 managers, educators and others it has trained directly or indirectly. It estimates there are 150,000 to 200,000 SDM users worldwide, with expected tripling in the next year. The majority of users were not using any method in the two months preceding SDM initiation; continuation rates have been comparable to other methods.

Because SDM can be used only by women who have regular 26 to 32 day cycles (with no more than two cycles out of this range/year), the TDM, based on self-observation of cervical secretions, offers an alternative FA approach. Given available funding and human resources, IRH, in close consultation with USAID, has prioritized research and program effort on SDM. A significant research agenda remains to expand program-based evidence on SDM and evaluating TDM's potential incorporation into FP/RH programs.

IRH has achieved progress with a lean, highly competent staff. IRH staff at headquarters and in country offices are recognized for their professionalism, dedication, credibility, responsiveness and strong communication skills. As SDM has taken off in recent years and there have been increasing requests for technical assistance and training, staff has assumed multiple responsibilities and is stretched thin. Its extreme responsiveness to opportunities, also encouraged by the USAID/W CTO and TA, has sometimes resulted in delays of some projects, particularly in research. IRH's finance and administrative systems need to be updated to keep pace with the sharply increased complexity of its work—in new settings, with new field staff, additional CA partners and contracts, etc. IRH is planning to upgrade its processes, including the development of a personnel and procedure manual for field staff, as well as other accounting, human resources, and financial systems, and is redeploying a mid-level staff person to develop and oversee such processes.

IRH has an excellent and highly collaborative relationship with USAID/W, particularly in the RTU Division. Research ideas are discussed early and USAID/W provides timely input and approvals for IRH initiated research, travel or other requests. The RTU Chief (also the AWARENESS CTO) and TA are seen as active supporters and wise counsel. The TA has been an energetic champion for FAM and the retiring Director of the Office of Population has done important outreach on FAM within the Office and to Missions.

IRH has had less interest from Missions. USAID Missions in countries where IRH has worked generally have positive views of its work and of the professionalism and responsiveness of staff but, with the exception of a handful willing to provide field support, IRH activities have been

exclusively core funded. There are several reasons for this: Missions' perception that IRH is a research-only organization with sufficient funding from core funds; busy HPN officers are not familiar with the specifics of IRH's work; disinterest or resistance to FAM because of unfounded concerns that introducing FAM into multi-method programs will result in large-scale switching from other methods. Even many supporters hold a view that SDM is a niche method with a narrow bandwidth of potential clients. In a couple of cases—including in settings with characteristics suggesting good potential for SDM (Philippines, El Salvador, Bolivia)--IRH was asked to discontinue program support due to the "administrative burden" for Missions trying to streamline multiple project support through consolidated bilaterals.

USAID/W needs to continue outreach on FAM through SOTA trainings, orientation of new hires, and communication during visits. And IRH needs to use simple, easy to read and absorb 'customer-oriented' ways to update USAID Missions (and others) tailored to their interests, e.g. FAM has the potential to address unmet need of important segments of the population and increase CPR especially in low CPR countries. USAID could also be instrumental in advancing program access to CB by including them in its commodities list.

IRH is now poised to undertake and study much wider scale up in a few countries that meet key criteria such as USAID/Mission willingness and field support funding, interested public and private partners with a wide reach to populations, existing infrastructure and a significant unmet need for FP which might be met by widening method choice.

Future Directions

There is still a significant research agenda needed to develop understandings for program scale up. Priorities are:

- Understanding conditions for and costs of broad scaling up;
- Better understanding how to position and help mainstream FAM as modern, effective contraceptive methods into family planning and NFP-only programs as well as improve service delivery quality and ensure their sustainability;
- Testing alternate training methodologies and expansion of provider categories;
- Determining effect of introducing FAM on user behaviors, male involvement and all method take-up;
- Developing and testing CB alternatives;
- Conducting studies on TDM to produce evidence on the pros and cons of its integration into programs;
- Assessing what is needed to ensure the sustainability of LAM, which has suffered erosion where the LINKAGES breastfeeding-focused project was not active;
- Continuing to explore an option to transition postpartum women to a FAM, if funds are available.

Follow-on Project

Based on what is needed to expand FAM knowledge, firm up SDM accomplishments, achieve its integration into broader family planning and reproductive health programs for large populations

and attain sustainability, our conclusion, shared by many others, is that there is a need for a follow-on project dedicated to FAM. Without such, current progress in introducing FAM methods likely would be seriously jeopardized. The follow on project should complete the research agenda and scale up in sentinel countries, allowing for a systematic culling of lessons learned during this scale up. Because IRH is considered particularly able to provide critical leadership and technical assistance on the above, we recommend a 6 to 8 year, non-competed project with a first phase in the RTU and a second phase in the SDI Divisions. We also recommend that funding be increased and that USAID do what is possible to stimulate field funding for all non-research activities. IRH needs to intensify its efforts to raise non-USAID funding from other bilateral and foundation sources.

Success can be considered achieved when:

- FAM has been fully integrated into programs for large populations and into CA, PVO headquarter programs and private and public agency FP portfolios as well as FBOs;
- FAM is one of the deliverables in USAID contracts;
- CycleBeads are included in USAID and UNFPA logistic systems;
- FAM use is documented via DHS and similar surveys.

We strongly feel these ambitious objectives can be achieved by a follow-on project, obviating the need for additional dedicated projects.

I. Introduction

The goal of the AWARENESS project, conducted by Georgetown University's Institute for Reproductive Health (IRH) is to improve and expand NFP services and develop new strategies and approaches to increase reproductive health awareness of individuals and communities in developing countries. The project addresses the needs of people who use or would like to use a natural method to avoid pregnancy but lack the information and skills to do so effectively.

The purpose of the present evaluation was to:

- Assess the performance of the AWARENESS project, relative to the goals and objectives of the cooperative agreement with the Office of Population and Reproductive Health;
- Assess the impact of research findings, new methods developed, and capacity building activities on family planning and reproductive health programs worldwide;
- Provide guidance to USAID on the scope for a future project and mechanisms of funding.

A. Background on the AWARENESS Project

Georgetown University has worked with USAID-funded fertility awareness based methods since 1985. The first cooperative agreement, the *Natural Family Planning Project:* (1985-1991), focused on expanding availability and improving quality of existing NFP methods (primarily Billings), working with NFP-only NGOs in 18 countries, and researchers in eight universities, on various aspects of natural family planning (NFP).

The second cooperative agreement, *Initiatives in Natural Family Planning and Breastfeeding, 1992-1997,* focused on increasing the accessibility, quality and appropriateness of NFP services through NFP organizations, other organizations that provide family planning, and health/development organizations and partnerships. Research included: testing a management information system; determining the safety of NFP for maternal health and pregnancy outcomes; conducting pilot studies on LAM; training of community based groups; and working on fertility awareness with adolescents.

The current project, AWARENESS: *Natural Family Planning and Reproductive Health Awareness Project (Awareness, 936-3088),* was authorized on July 7, 1997 and is being implemented by IRH through a cooperative agreement (HRN-A-00-97-00011). The first five-year cooperative agreement was extended for the second five-year period to end on May 31, 2007. The project was authorized at a funding level of $42,687,621 for the ten-year period; $29,318,000 has been obligated through 2005. The project's scope of work was adjusted following a management review in 2002, to better reflect needs and opportunities based on progress made and potential. The original project had included increase of "Reproductive Health Awareness" in its proposed outcomes. After several years experience that included the development of SDM, IRH felt that the broad range of topics in Reproductive Health would complicate its work and distract from its primary goal of acceptance of Fertility Awareness

Methods into programs[•]. On this basis IRH decided to change the term and now uses Fertility Awareness as a measurable outcome.

The AWARENESS project contributes specifically to USAID's Global Health Bureau Strategic Objective number one (SO1): advance and support voluntary family planning and reproductive health programs worldwide. All three Intermediate Results (IR) are addressed through this project:

- IR 1: global leadership exercised in FP/RH policy, advocacy, and services
- IR 2: knowledge generated, organized, and communicated to advance best practices
- IR 3: support provided to the field to implement effective and sustainable FP/RH programs (See IRH results framework, Appendix 1).

The objectives of the agreement with illustrative activities are:

1. Making simple NFP methods available
    - Develop and test new NFP methods
    - Provide and disseminate information on new NFP methods
2. Improving NFP service delivery systems
    - Increase capacity of governments and NGOs to provide NFP
3. Mainstreaming NFP into integrated reproductive health and other services
    - Incorporate NFP into existing FP/RH norms and guidelines at global and country levels
    - Operations research to test SDM introduction into FP/RH programs
    - Collaborate with service delivery and donor organizations on NFP
4. Incorporating reproductive health and fertility awareness (FA) into programs and services
    - Increase male involvement to increase couple communication and FP use
    - Integrate FA into existing FP programs

B. Evaluation Methodology

The evaluation was conducted by a team of three consultants, with diverse yet complementary skills, in February-March 2006. The evaluation team was briefed by USAID Research and Technology Utilization and Service Delivery Improvement Divisions as well as by the IRH management staff. IRH prepared a self-evaluation addressing each question in the scope of work. In addition, the team reviewed key policy, training, and strategy documents; research reports; country reports and summaries; and other data from a comprehensive compilation assembled by IRH.

The evaluation team interviewed over 100 individuals from diverse agencies: USAID/Washington and Mission staff, IRH/Washington and field office staff, WHO, research agencies, cooperating agencies (CAs), private voluntary organizations (PVOs), IPPF affiliates, and Ministries of Health, Social Security agencies and NGOs in countries where IRH works.

[•] In the text of this report, we use FAM instead of NFP to refer to SDM and TDM as modern methods.

India, Peru and Rwanda were visited, each by one team member. The three countries visited were selected by IRH and USAID based on level of resources invested in research, size of programs, multiplicity of research studies implemented, potential for program scale-up and support by the USAID Mission.

For more complete information on the scope of work and questions provided by USAID, see Appendix 2. Evaluation methodology, additional questions developed by the team and evaluation timetable with key dates are in Appendix 3; a list of persons interviewed is in Appendix 4.

II. Findings

A. Research

Research Capacity

IRH has strong credibility as a research organization resulting from the rigor with which research has been conducted, IRH's affiliation with a research university, and its partnership with other recognized research organizations (CDC, FHI, Population Council). In addition, in field research, they have engaged highly qualified researchers and research groups known for their qualifications and integrity. The IRH staff has strong skills in various research modalities ranging from bio-medical and bio-statistical to operations research and program evaluation.

When conducting research in the field, IRH is known for developing schedules, keeping to time projections and, if something comes up to change those, advising their research contractors well in advance. They are highly regarded by people who have experience with the challenges of field research in developing country settings. A recognized expert on FP use-efficacy has praised the rigor with which the IRH efficacy trials were conducted, giving the results merited acceptance.

There have been some delays in the research process that IRH has acknowledged in its self-assessment. Given the volume of research that has been undertaken under the AWARENESS project and the limited number of staff dedicated to the research function, there have been several bottlenecks in the proposal review process. IRH has proposed that this problem be addressed by either 1) increasing the number of staff with strong research qualifications or 2) shifting non-research tasks/assignments, such as country monitoring, and training away from research staff, thereby allowing them to dedicate more time to research issues. That said, IRH still has achieved a praiseworthy level of quality research completion during this project.

IRH has an excellent working relationship with the RTU Division, and this has facilitated the timely approval by USAID of their research proposals. IRH staff meet with RTU staff when new research ideas are in the offing. Through early joint assessment of the value of proposed research, decisions can be made to move projects forward and, with on-going communication, the approval process is facilitated.

Given the size of IRH and its staffing levels, the research agenda that they have managed to undertake under the AWARENESS project has been impressive. As important, the quality of the research has been very high, and is so regarded by USAID and field authorities.

Research Results

IRH has undertaken a systematic and rigorous approach to the development and testing of SDM and TDM. Secondary analyses of very large data sets provided by WHO which established the theoretical and biomedical basis upon which the methods were conceptualized, were followed by pilot and long-term tests of efficacy. SDM was found to be more than 95% effective with correct use, and 88 % effective in typical use, and TDM is 96% effective with correct use and almost as effective as SDM in typical use**.** Recently, IRH has conducted preliminary research on a "bridging method" for post-partum women not protected by LAM who want to transition to another natural method such as SDM or TDM. The algorithm so far developed is too complicated and provider-intensive to be easily taught to potential users; further research will be needed to simplify a bridging method for these women.

Most of the research program carried out to date has focused on SDM; research on the TDM is less complete. The biomedical/efficacy studies completed for both methods have been methodically followed with studies that assess and document a range of factors affecting the introduction of SDM into existing programs, either as case studies or as operations research; these have included user satisfaction studies, approaches to counseling in service delivery, SDM introduction in non-clinical delivery systems, effects of partner participation, comparisons of use in urban and rural settings, and the effects of having male providers engage in educating men about SDM.

Other studies have addressed the feasibility of integrating SDM in multi-method family planning programs. A large, three country study to test the effects of scaling-up the inclusion of SDM is underway; it is looking at 1) the extent to which providers offer the SDM in a non-biased manner, 2) the effects of SDM introduction on new family planning users and method mix, and 3) effect on contraceptive prevalence, knowledge and attitudes. Preliminary results from Peru and Rwanda show that there is significant potential demand but some providers erect unnecessary medical barriers to SDM use. Results from India, Rwanda, and Peru show that providers score better offering SDM than other modern methods, but quality scores for all methods are low in India, and could be improved in Rwanda and Peru. Results from these studies will be available in late 2006.

Additional research in progress on SDM includes a comparison of a new knowledge improvement tool (KIT) vs. traditional refresher group training on provider skills and knowledge; a three-country social marketing study using a common research protocol; tests of scaling up interventions, including long-term method use and continuation rates; the costs of SDM introduction and a SDM user tool study. A final study in Bolivia is examining the impact of a behavior change communication campaign on public awareness and provider attitudes.

In addition to the TDM efficacy study completed in 2003, a long-term follow-up on efficacy and method continuation by study participants was completed in 2005. It found that two-thirds of

women who entered the study were using the method two years later. Current OR studies on TDM are assessing whether correct method use, continuation and satisfaction are affected by timing of instruction during the menstrual cycle and assessing the feasibility of introducing TDM into regular service delivery systems.

NOTE: Results from the above research agenda are incorporated in appropriate sections of this report and can be found in a matrix with IRH's research studies, research questions, locations, dates, partner organizations, and key findings in Appendix 5.

Future Research Agenda

There is an extensive research agenda yet to be undertaken. The research areas fall into the following broad categories:

- Additional research on SDM and its role in introducing new users to family planning and consequences of that introduction, including method switching and/or abandonment over time
- Comparisons of the acceptance, effectiveness and uptake of SDM using alternatives to CycleBeads, e.g. the paper image of CB now having a preliminary test in Guatemala
- Multiple studies on TDM to establish the knowledge base for introduction and scale-up of the method, including training requirements, testing materials and job aids, protocol development, etc.
- Preconditions and determinants of successful SDM scale-up to large populations, including level of investment required to achieve sustainable FAM integration
- Delivery of FAM by a broader range of non-medical providers, including the private sector
- Clinical research to determine women's eligibility for use of SDM over the reproductive life cycle as a way of reassuring program managers of the value of integrating FAM, and its potential ´market share
- Gender related studies to determine how best to engage with men in method adoption and continuation, and evaluate the outcomes in terms of any changes in empowerment of the woman partner
- Repositioning and strengthening the role of LAM in post-partum programs including the development of a bridging method for postpartum women

The existing body of research is insufficient to permit the identification of necessary conditions for the successful integration of SDM into very large-scale (national) programs. Policy makers and program decision makers seek this kind of evidence before moving forward with major scale-up activities. Through prior and on-going initiatives IRH has created opportunities for a follow-on project to test wider scale-up strategies to integrate FAM nationwide (Peru), into new provinces (Rwanda) or states (India).

Private sector opportunities have not yet been fully studied, with current findings limited to a three-country social marketing study of one non-clinical provider type (pharmacists). Other private sector opportunities may include involving new, non-health related groups as promoters

and providers such as market women, micro-credit groups and owners of small convenience stores.

The Recommendations Section of the report provides more information on future research needed.

Dissemination of Findings

IRH's great care in conducting rigorous research, documenting research results and pursuing a variety of dissemination strategies have resulted in inclusion of SDM and TDM as modern FP methods in documents produced by agencies of global importance as well as in locally/regionally respected health publications and the popular press. IRH has taken a proactive role in inserting itself wherever dissemination and knowledge diffusion opportunities are identified. USAID and WHO validation of FAM have influenced numerous Ministries of Health, Social Security Agencies, IPPF affiliates and private organizations to incorporate the methods into their ongoing programs. FAM-related efforts have increased method awareness and interest in policy and decision-making quarters and service delivery organizations.

IRH's results have been published in numerous peer-reviewed journals: *Contraception, Fertility and Sterility, International Family Planning Perspectives, Studies in Family Planning* and others. (See Appendix 8 for a list of publications in peer review journals).

Organizations with global influence have reviewed results and included SDM as a modern method in their publications and communication/training materials. WHO, USAID, JHU/CCP, IPPF and other agencies with global reach include sections of modern fertility awareness methods and LAM in their publications. A 2005 issue of *Populations Reports on New Contraceptive Methods* was devoted to FAM and they are also included in *The Essentials of Contraceptive Technology*. The *IPPF Medical Bulletin*, which reaches its worldwide affiliates and many independent subscribers, has devoted two issues to SDM. The 18th edition of *Contraceptive Technology*, the classic family planning "bible" edited by R. Hatcher et al, has a chapter on FAM which includes details on SDM as well as a chapter on LAM; TDM is mentioned as a simple modern method in development. SDM has also been featured in at least three issues of *Contraceptive Technology Updates*.

USAID has been instrumental in the dissemination of the IRH results. The MAQ Initiative has had IRH participation in many national and regional events and in the related Mini-Universities. A module on SDM, created on IRH initiative, is one of the first six Best Practices' e-Learning modules. These e-Learning modules are intended to provide ongoing technical updates, and may become a requirement, for new Mission Health Officers. FAM are included in the *Global Health Technical Briefs* distributed to all USAID Health and Population officers in the US and abroad. USAID/W and some Missions have furthered dissemination and encouraged the inclusion of SDM, TDM and LAM in the scope of work of agencies working with USAID funding, including bilateral consortia, FP and development CAs, PVO's and NGOs.

The World Health Organization includes SDM and LAM in its Four Cornerstones publications: 1) *Improving Access to Quality Care in Family Planning, Medical Eligibility Criteria for*

Contraceptive Use; 2) Selected Practice Recommendations for Contraceptive Use; 3) Implementing Best Practices: Decision Making Tool (flipchart) and *4)* the recently revised *Global Handbook for Family Planning*. The Implementing Best Practices (IBP) Initiative is an interagency effort of WHO (secretariat), USAID, and CAs concerned with the process of identifying "what works," disseminating this information and providing technical expertise to support implementation in policies, norms and programs. IBP conducts regional workshops to promote evidence-based practices and SDM was identified as a best practice in 2002. WHO also responds to country requests for strategic analysis of local FP programs consisting of situation analysis, OR, and scale-up of positive practices. This WHO activity has resulted in raising awareness of the SDM in countries where IRH has not been active; a recent example is Vietnam: as a result of WHO-MOH/V collaboration, decision makers learned about SDM for the first time and were provided with CycleBead samples. As positive as these initiatives are, however, it is difficult to envision how such brief informational events can result in advancing SDM inclusion in national programs without substantial additional TA and provision of a stock of CB.

IRH has presented its research findings at large annual conferences, meetings and events of national and international importance, such as APHA, PAA, Global Health Council, FIGO, and the Psychosocial Workshop.

IRH also organizes country and regional dissemination meetings to present and discuss research results and lessons learned in the implementation of its agenda. These events are attended by high-level government officials and representatives from local and regional CAs, NGOs, Ob-Gyn Societies, etc. In order to get the information into the public arena, IRH has invited journalists to them and has provided general interest articles on SDM, TDM and LAM for publications reaching large audiences.

In the last few years, there has been significant media attention to SDM which provides an effective vehicle for raising awareness of the method among the general public and may help overcome biases and barriers surrounding natural methods. US-based (e.g., *The Wall Street Journal*, *The Washington Post*) and other country newspapers have published articles on the SDM. Television programs in the US (e.g., CNN, local news programs) and IRH program countries also have featured the SDM, as has the electronic media. Google searches on SDM and "CycleBeads" yield hundreds of thousands of entries, including health websites and other fora. TDM is also gaining identity in electronic search engines.

For a specific example of successful dissemination efforts, in Rwanda IRH has achieved wide recognition and has worked with a range of actors to implement SDM in designated provinces—MinSante (MOH), faith-based organizations and the two major projects run by INTRAhealth (Twubakame and Capacity Project). SDM has been featured in published articles written by the WHO country representative. IRH is an active participant in national fora such as the FP Task Force, a very effective coordinating mechanisms in the health area and IEC inter-agency and donor working group. An indication of its reputation as an effective doer, IRH has recently been asked to participate in the subgroup charged with organizing the upcoming presidential debate on family planning.

Dissemination at the community level has been less vigorous than that with professional, and decision maker and policy audiences. IRH has not employed more vigorous awareness raising activities due to a concern about generating demand in areas where the SDM is not offered, but also due to lack of funds, and unwillingness on the part of USAID to conduct such campaigns, because they are opposed to the promotion of single methods.

At community level, IRH has employed traditional means of informing potential users but moving forward, it will need to design and greatly increase locally and culturally appropriate dissemination strategies to reach new audiences (see recommendations section). We recommend that funding be redirected to do significant dissemination in specific countries. For IRH to do community-based IEC, it would need to be coordinated with IEC on other methods, to ensure informed choice (including no violations of the Tiarht amendment).

In summary, IRH has utilized multiple traditional and modern strategies to get its messages out to a wide variety of audiences and to assist program planners and implementers, trainers and providers; SDM, and to a lesser extent TDM, have achieved policy and program identity in many countries, resulting in their inclusion in national norms and guidelines and service programs. Increasing public awareness has created demand for "the Necklace" leading to multiple requests from public and private agencies for IRH assistance in training and materials, including CycleBeads.

Still, many interviewed persons do not have an up-to-date notion about IRH's work. The evaluation team does not view this as a fault of the project, but rather a reflection of the challenges in keeping abreast of the work of others, even if highly related to one's own work. It does speak to the need to use very 'customer-oriented' ways to update CAs, USAID/W, Missions and others on highlights of interest to them.

Despite the high quality of all the dissemination efforts, new audiences need to be reached and strategies still need development to facilitate mainstreaming FAM and overcoming misperceptions; there are still many potential supporters who are not fully informed, as well as some skeptics in Missions, CA staff in the field and at headquarters. These would benefit from distilled, user-friendly, locally applicable efforts summarizing research results and providing implementation lessons-learned and how-to advice on incorporating SDM into their multi-method programs. Responding to a suggestion made during the evaluation presentation to USAID/W, Appendix 10 is a one-page sample summary which could be used by USAID and IRH to disseminate key facts and accomplishments to very busy health personnel in the field.

B. Research to Practice

IRH's Conceptual Model

IRH has applied the Research-to-Practice approach and codified it in a visual poster, which provides graphic representation and sequencing of work on all its key elements. The model involves the following steps:

1. Establishing the concept of the "standard rule:" there are possible equations on fertility that work for a large segment of women in reproductive health.
2. Identifying a formula that could be used to identify fertile times•. Testing the formula in actual use to determine perfect and common use efficacy in preventing pregnancy.
3. Conducting OR to identify best practices for training, service delivery, IEC.
4. Providing training and TA to programs wishing to add FAM to their menu
5. Testing models for scale-up.

IRH clinical research studies have provided evidence to back up steps 1 and 2 for both SDM and TDM. Steps 3, 4 and 5, which focus on country/culture specific program research and technical assistance, are more advanced for SDM and lag behind for TDM. The poster illustrates progress on all elements of the research-to-practice conceptual model and demonstrates that the process is accelerating as evidenced by the growing numbers of partners, countries, policies, curricula, etc. to December 2005.

IRH had "introduced" SDM in 25 countries, with differing levels of support and investment. Some of the critical components of success in integration of SDM into programs include collaborative relationships and partnerships with 1) international organizations which have facilitated IRH's ability to move forward at national and regional levels; 2) USAID Missions, MOHs, CAs and PVOs working at country level 3) local NGOs and 4) FBOs.

Experience has shown that while SDM is an easily taught and practiced method, it is easier to introduce the method into new programs and more complex to attempt to incorporate it into established FP programs. IRH has worked to build capacity by establishing training capacity, providing user-friendly materials that can be adapted, and working with FBOs and multi-method agencies to incorporate FAM. IRH's new Implementation Guide should also be very useful in addressing issues arising from the introduction of SDM into established programs.

IRH's efforts described below are directed at facilitating FAM introduction into programs at country and site levels.

FAM Introduction Tools and Strategies

Cyclebeads

CycleBeads, as a teaching aid and as a possible long-term motivator of client SDM use, are a central feature of IRH efforts to introduce and popularize SDM and to integrate it into existing FP programs. For established users, in contrast to OCs, injectables, and condoms, CBs do not need continuous re-supply. In multiple interviews with field-based partner staff and in countries

• For SDM, the rule is: "if most of your cycles are between 26 to 32 days, fertility is likely from day 8 to 19 of the menstrual cycle" (note that 95% efficacy takes into account up to 2 out-of-range cycles per year); for the TDM the algorithm is: "you may be fertile if you have noted secretions today or yesterday". Both these formulas lead to advice that, if not wishing to become pregnant, a couple needs to either abstain or use condoms during the fertile days of each cycle. During the remainder cycle days, the couple can have unprotected intercourse with very low or no risk of pregnancy.

visited by the evaluation team, CBs were found to be an important marketing tool for SDM. While not really a "commodity" in the usual sense of the word in FP programs, they nonetheless require a mechanism/process for being incorporated in the FP program supply chain. Most of the CBs so far distributed have been provided gratis to programs by IRH directly through the Washington office or indirectly through an IRH in-country office. However, recently, large orders have been placed by the Rwanda "Twubakane" (IntraHealth) project, MSH projects in Haiti and Senegal and PSI's Nigeria local affiliate. Also, the AFFORD social marketing project in Uganda plans to purchase CB.

Although IRH has made arrangements in some countries for a local agency to be the in-country source for CBs, these arrangements have not always been effective, in part due to a lack of communication about order processing. For example, in Bolivia, as a result of their decentralization process, the Ministry of Health does not purchase FP commodities; purchasing is now handled at the *municipio* level. Neither the *municipio* staff nor the staff at the Ministry appears to have information about purchasing CBs through ProSalud, the NGO selected by USAID/B to serve as the private sector local commodity and CB distributor, according to people interviewed.

In DRC, the re-branding of CBs under the *Confiance* label in the PSI social marketing project has resulted in these branded CBs not being suitable for use in governmental programs; other NGO providers shun them as well. PSI did serve as the main distribution point for a time, but they decided to stop doing this as of early 2006; IRH is working with USAID, the MOH, and other partners to establish a more permanent solution.

In Rwanda, IRH is working with the MOH procurement regulatory body to have CBs added to the commodities list which would mean they could be included in MOH requests to UNFPA and/or USAID for fulfillment if these organizations had CycleBeads on their commodities list. However, until that happens, there is no unified plan for distribution of CycleBeads (for example, Twubakane project purchased 20,000 sets but doesn´t have a distribution plan in place) and they remain outside the regularized logistical supply system.

In Peru, SDM has been incorporated in the MOH norms and policies for FP. However, the MOH purchases, exclusively through UNFPA, all of the FP commodities that are made available through its service points. Because CBs are not on the UNFPA commodity list, they cannot be acquired through normal purchasing processes, making efforts to increase their availability problematic. This is another example that reemphasizes the need to have CBs added to the UNFPA commodities list.

A cost consideration when SDM is further mainstreamed is the downside of purchasing and shipping small orders, which can nearly double the cost per CB unit. For example, a spokesperson for Cycle Technologies reported that a recent shipment of 2000 CBs from its factory in Hong Kong to DRC had cost $1500 ($.75 per unit). If 10,000 units had been purchased, the shipping charge would have been around $.25 per unit, and if 100,000 units had been purchased, the unit cost would have been between $.10 and .15 per unit. Another reason supporting the idea of adding CBs to the USAID commodities list is USAID-negotiated lower shipping prices.

Cost of CBs is seen by some as a barrier to wide and rapid expansion of access to SDM. This is compounded by the fact that FP commodities are provided free of charge by most public and some private service agencies and CBs today are not considered a commodity. Administrators of several provider organizations perceive the approximately $1/necklace price as making it an unaffordable method within their programs. Usually, they are making inappropriate comparisons of the costs of a cycle of pills or a single DMPA dose to the cost of the necklace, not recognizing that if the cost of CBs is amortized over the five-year expected life of a necklace, it is approximately 2 cents per month per user. Moreover, the "necklace" is not "consumed" during its lifecycle, and may end up serving as a instructional tool and family planning method for several women during that period.

To address a possible barrier to scaling-up imposed by CB cost, IRH has begun research on an image-on-paper version of the necklace with different shaped beads representing fertile and non-fertile phases of the menstrual cycle. The study currently underway in Guatemala, randomizes users given the beads vs. the paper versions included in a personal record or "carnet" (rather than giving them a choice). It will compare their acceptability, correct method use, continuation, user satisfaction and cost effectiveness of the two aids. Results will be available by late 2006. If the paper version compares favorably, further study should be undertaken to see if it is as attractive as CBs in recruiting users. CBs have been an important marketing tool for SDM; therefore, if studies indicate that uptake of the paper-based aid is equivalent to uptake with CBs, its introduction into other country family planning programs should be piloted and scaled-up accordingly. Further, to mitigate a cost barrier, USAID/W should re-circulate its notice on negotiated discounted pricing on small volume orders of CBs. Under this agreement, any recipient of USAID funds can purchase as few as 500 CB units and obtain the lowest USAID price (approximately one dollar per unit). It appears that the original distribution of this information often did not get beyond USAID/Missions to program managers and operators.

Despite the above, some research has demonstrated that users are willing to pay for CycleBeads. Research in Ecuador found that clients of the FP NGO CEMOPLAF reported they would be willing to pay up to $5 (US) for CBs. Midwives in private practice in Peru charge a visit fee that includes cost-recovery for the CB, although the actual number of units dispensed so far through this INPPARES network of private practices is not significant. NGOs in India have reported that CB cost is not a barrier even in poor areas of Delhi and have charged from $1.50 to $4.

Private sector pricing obviously precludes extremely impoverished women from accessing the method. Moreover, some MOHs prohibit charging clients for any service or family planning method, thereby eliminating any cost-recovery effort. A number of these public sector agencies are eagerly awaiting the outcomes of the paper necklace studies to determine if this will be a suitable, low cost alternative to CBs.

IRH has been understandably concerned about maintaining the quality and integrity in the manufacture of the CB tool, noting that faulty manufacture could result not only in a product with a shorter life expectancy but, more importantly could, if incorrectly assembled, result in unintended and unwanted pregnancies. To help others understand the quality requirements for manufacture of CBs, IRH worked with PATH to develop a manual, *CycleBeads Procurement*

and Production Guide, that includes procedures for cost analysis of various production/assembly options.

Program Guidance and Aids

IRH has developed, pre-tested, translated and disseminated a range of technical and programmatic documents to assist SDM integration into a variety of programs; these documents are available to and have been used by its field staff and partners as well as by agencies not directly affiliated with IRH. Publications, which have been praised for quality and ease of use, include: informational documents, training modules and job aids, counseling guides, service implementation guides, Guidance Bulletins directed to USAID Missions, etc. Most have been produced in English, Spanish and French and some in Hindi, Portuguese and other languages (e.g. Kinyarwanda). In collaboration with FHI, IRH has also developed and distributed a Fertility Awareness module for adolescents and young people, *My Changing Body: Fertility Awareness for Young People,* which can be used to teach fertility awareness to young girls (and boys) and to fill the FA gap found in FP curricula for older youth.

IRH has utilized electronic material distribution widely. Many of the above materials are available on the IRH website and a number are widely distributed in interactive electronic formats; these include SDM Learning Modules (online module in USAID e-Learning Center, training course on IRH website), tools for programs and providers (including waiting room videos) and tools for trainers (videos, DVD on counseling clients, CD-ROM with training manual and job aids). To date, IRH staff responsible for CD-based and other interactive digital documents are uncertain of the degree to which they are being used. In many developing countries, potential users do not have CD ROM readers or, if they do, are reported to be intimidated by them.

IRH's regularly updated website (www.IRH.org) is well designed, user-friendly and includes many useful and relevant links. No detailed analysis of users has been done, in part because the data captured on website visitors is limited. What IRH has documented is an increased number of visitors during dissemination efforts and conferences and increased downloading of IRH materials in English, Spanish and French.

Country-level Approaches

FAM introduction through technical assistance: As noted earlier, IRH has largely been opportunistic in its selection of countries in which to work, taking advantage of any interest wherever it is manifested. Today, by virtue of geographic proximity and similarity of culture and language, some countries may be applying lessons learned in others, thereby fortifying FAM inclusion in a variety of programs, both public and private. IRH has stimulated these efforts by conducting regional meetings and inviting other country decision makers and program managers to visit on-going programs. A large number of requests for TA remain pending due to staffing limitations.

IRH is now beginning to take a more strategic approach to country selection for FAM expansion, using potential method-user profiles, Mission support, possible partners (public, private and social marketing agencies) and other criteria for initiating collaboration. An example is Nigeria, which has recently been added to the IRH portfolio. IRH conducted a first training workshop

with NGOs, which resulted in a request by the MOH for a similar activity. Nigeria is appropriate for FAM introduction, because it has the largest population in Africa, has a total fertility rate of 5.9, low CPR (8% modern method use) and high unmet need; it also has large tribal areas and a significant religious population (both Christian and Muslim) who may be particularly interested in FAM.

IRH has not been able to sustain FAM work in all countries, even those which would appear to be ideally suited for widespread FAM uptake. For example, after IRH started working with multi-method agencies in the Philippines, a country with a large, devout Catholic population, IRH and its local staff were subjected to strong attacks from the Catholic Hierarchy accusing IRH of "destroying NFP." The popular media fanned the controversy. USAID requested IRH to withdraw from the country, stating management burden and its decision to work with the MOH only, which by then had rescinded the official policy guidelines on FAM. As a result of IRH´s withdrawal, a pre-established local NGO, IRH/Philippines, continued to be active in SDM with modest funding from multilateral organizations and foundations. It works with the several provincial decentralized MOHs and small local development agencies. Recently, USAID/Manila, with USAID/W encouragement, gave concurrence for IRH to re-visit. This opening coincides with the MOH's re-incorporation of SDM into its program; the latter has requested IRH/P to draft the clinical standards for it and will follow with an "Administrative Order" advising all service delivery personnel to offer these services.

In response to requests from interested agencies, IRH has visited many countries and provided technical assistance and materials to demonstrate appropriateness and potential demand for FAM, leading to its introduction into multi-method service agencies and NFP-only providers (FBOs). How effective each of these multiple, scattered TA efforts is, as yet, unknown; their sheer volume may be an impediment for IRH to concentrate its capacity in needed key areas. With increasing interest in incorporating SDM into broad FP programs around the world, IRH's ability to provide TA has been limited by the availability of human and financial resources exacerbated by reluctance on the part of Missions and CAs to provide funding for TA and scale-up of successful strategies.

One of the main ways that IRH has expanded FAM awareness and delivery capacity has been through provider training. With the exception of FBO providers who do not accept other methods, IRH has actively worked with partners to include FAM in CTUs and includes detailed condom training to manage the fertile days.

OR has demonstrated that many different categories of providers can be trained to teach women and couples to use SDM: physicians, nurses and nurse auxiliaries, professional midwives and TBAs, and community workers whether previously involved in health education, and whether literate or not. Both men and women have been able to provide the method; men may be particularly effective in promotion to men and couples but they often spend less time in the community than women. Pharmacists were trained in a three country social marketing study. In Ecuador, the first country for which results have been reported, this strategy led to a slight increase in SDM demand/CB sales, in the pharmacies and in the implementing NGO clinics. Results from the other countries, Benin and DRC, will be forthcoming shortly and it is possible that this strategy will be more effective in these countries with low CPR.

IRH has developed and translated training modules for a variety of provider profiles and literacy skills, conducted TOTs, and trained providers directly or with partners' funding support. The extensively pre-tested training guides present FAM in the context of informed choice, and are very comprehensive and adaptable to different provider categories and other audiences. SDM training, which requires basic knowledge of woman's anatomy and physiology, can be an important facilitator for training in other methods, by providing bases for how methods work.

To expand local capacity and service sustainability, IRH has sponsored many TOTs with participants from international and local agencies, assisted new trainers to prepare new FAM providers, and been directly involved in provider training. Most training activities were conducted with core funding but in the last 12 to 24 months some missions and CAs have been willing to share costs.

The table below shows participation in TOTs from international and national public and private agencies.

Country	Partners Trained as Trainers in SDM
Benin	PSI, MOH, local NGOs
Bolivia	EngenderHealth, MOH
Burkina Faso	JHPIEGO, MOH
DR Congo	PSI, CARE, CRS, SANRU, MOH
Ecuador	CEMOPLAF, MOH
Ethiopia	Pathfinder, NGOs
Guatemala	URC, Project Hope, MOH, Social Security, local NGOs
Haiti	MSH, NGOs, HHF (Haitian Health Foundation)
Honduras	CEVIFA, MOH, ASHONPLAFA
India	CEDPA, CARE, MOH, local NGOs, Pathfinder, World Vision
Madagascar	Chemonics, JHPIEGO, MOH, local NGOs
Nicaragua	MSH, CRS, MOH, NGOs
Peru	ADRA,MOH, Social Security, professional associations, local NGOs
Philippines	Chemonics, MSH, MOH
Rwanda	IntraHealth, MOH, local NGOs
Senegal	MSH, MOH, local NGOs
Zambia	Population Council, MOH

IRH estimates that there are approximately 10,000 trained SDM providers, not including those trained by non-partners or without IRH assistance which are not possible to count due to lack of reporting.

As of December 2005, excluding the Philippines, El Salvador and Nicaragua, providers trained with IRH's direct or indirect involvement include:

- 784 MDs
- 3,105 nurses/nurse auxiliaries
- 942 professional midwives

- 4,193 community workers
- 335 pharmacists

Over 5000 existing Health Promoters have also been trained in FAM; this cadre does not provide the method but raises awareness in the community, educates and refers to trained providers. Finally, 2,088 program managers, educators, etc. have also been trained.

Demand Creation

Dissemination of information on FAM at community and individual levels has been less fully developed than that directed to international agencies and US stakeholders. IRH has not expanded this work to country programs due to lack of funds and reluctance on the part of USAID to assist single method communication efforts as well as to avoid generating demand in areas where SDM is not available. IRH employs local demand creation strategies where studies take place and trained providers are in place: traditional means such as wall paintings, posters and signs, identifying logos on provider homes and clinics, street theater, circulating megaphones, "branded" tee shirts donated to cycle-taxi drivers, as well as limited use of radio advertising in some locations. There is also encouragement of person-to-person information-sharing and method promotion. As described above, social marketing efforts have been limited to pharmacies and not been completely successful up to now; social marketing efforts should not be abandoned however, but rather expanded using locally appropriate and affordable media for new audience segments and differing distribution sites.

Collaboration with Partners

IRH has achieved widespread collaboration with multiple partners: national and local service delivery agencies (e.g. MOH, local NGOs and FBOs), international NGOs and CAs. These agencies view IRH as very collaborative and responsive while noting that its staff has been excellent at raising SDM awareness. In 12 countries where studies have been implemented, IRH has worked with over 20 research-linked national and international agencies and dozens of private and public service delivery agencies including MOHs, Social Security Agencies, large and small NGOs, CAs and FBOs; a partial list is found in the TOT table in previous page.

As both a FAM mainstreaming and funding strategy, IRH has also worked hard to partner with other CAs on competitive procurements and is included on the CAPACITY and Expanding Service Delivery (ESD) and the SanteNet (Chemonics) Madagascar projects and has signed letters of collaboration for a host of other projects. However, it is not yet clear whether these "paper partnerships" will result in substantial involvement for IRH in these projects.

AWARENESS has also collaborated with many FBOs, primarily Catholic and or other Christian ones (e.g. CRS, Caritas, CEVIFA, ADRA, Conduite de la Fecondite). It would have been a logical assumption that NFP-only FBOs that had collaborated with IRH in the past would want to continue, especially since the new FA methods developed are much simpler to teach and use than the symptothermal, Billings and other methods used by them. In fact, some of these organizations became

IRH opponents giving one or more reasons: because AWARENESS works with multi-method agencies and protocols, which include advice on alternatives to abstinence during fertile days and, in some cases, EC, or because FBOs were protecting their work on Billings and similar symptom-based methods and perceived all calendar methods to be ineffective. Despite the above, IRH has achieved acceptance from FBOs that had previously been suspicious of the intentions of the AWARENESS project. Collaboration resulted from repeated contact and negotiations and reassurance that abstinence only can be the advice these FBOs give their users.

In some settings, strong and unexpected coalitions have emerged between FBOs and multi-method service agencies. For example, in Honduras, IRH used an excellent trainer from an FBO, CEVIFA, to train trainers in the MOH. This relationship continues to date and both types of organizations are appreciative of each other. In the Democratic Republic of Congo, IRH has worked with a very broad range of actors: faith based groups such as Conduite de la Fecondite and CRS, a variety of development NGOs (e.g. Jane Goodall Institute), and FP specialized agencies (PSI). IRH in the DRC is seen as having an important bridging role by bringing together groups that could relate to it but not, initially, to each other by being perceived at opposite ends of the FP spectrum (e.g. PSI and some faith-based groups).

There are new opportunities to resume working with some previous partner FBOs as well as with some new ones. In the Philippines, where the Catholic hierarchy had been opposed to the IRH work, several dioceses reportedly have approved SDM for their parishioners and some members of the Philippine Catholic Bishop's conference have also done so (many others still oppose SDM). A new opportunity to work with abstinence-only with an FBO federation is now emerging with an African Federation of Catholic Organizations. The decision makers in this large agency will meet with IRH to discuss and plan adding the TDM to Billings, which they now teach.

Not all FBO opportunities are found in Christian majority countries; as an example, in India, there are over 4,500 Catholic health delivery institutions and the non-Catholic Christian Medical Association has over 6000 hospitals. Plan/India and The Futures Group stated they plan to work with these associations. The FGI Chief of Party informed that he has had a request for an article on SDM to be published in *Health in Abundance*, the Journal of the Commission for Healthcare of the Catholic Bishops' Conference of India.

Results

Number of Users Worldwide

While IRH is not directly involved in teaching SDM use, it estimates that there are 150,000-200,000 SDM users worldwide with an expected tripling of these numbers by the time AWARENESS terminates in 2007. These estimates depend on various sources, some more reliable than others. In several countries, SDM prevalence has been documented in population based surveys even if it was only available in small geographic areas. For example, in Rwanda, including only the 28 sites then offering SDM, of 10.3% of women reporting modern method use in the 2005 DHS, 0.5% were SDM users; in Bolivia, SDM accounted for 0.1% of total prevalence (approximately 0.3% of modern method users) and in the Philippines, the 2004-05 FP

Survey documented SDM prevalence of 0.1%, even though IRH/P has not worked in the entire country. In a province where IRH/P has worked intensively SDM prevalence was 1%.

In contrast, user data for the TDM is miniscule as research lags significantly behind that of SDM. IRH estimates there may be a total of no more that 500 users, all enrolled in efficacy trials and on-going OR studies.

To put the above population-based prevalence in perspective, accounting for the short time and relatively small geographic areas where SDM has been available, IRH has provided the following estimated numbers of SDM providers and users:

- In Rwanda, IRH has worked since 2003, SDM today is available in 68 sites, there are 1,400 providers and by Dec. 2005, 3,660 users were recorded
- In Bolivia, there are 1,400 providers and 12,000 SDM users since 2003
- In DRC, there are 1,200 providers and 4000 users since 2004
- In Peru, there are 500 providers and an estimated 5,000 users

See Appendix 7 for more specific country-based information on providers, users and CB distributed.

SDM prevalence is bound to mushroom when scale-up takes place. IRH expects that it will reach 2-3% of new users in populations with moderate to high total prevalence and as high as 30% in populations living in lower prevalence settings including isolated rural populations, highly mobile populations, indigenous/tribal populations. Examples suggesting these rates are CEMOPLAF, the Ecuadorian NGO, which reported that SDM accounted for 2% of its new FP users; Benin, where the NGO OSV-Jordan, working primarily in rural populations with extremely low CPR, reports that SDM users account for 30% of all new users; and Guatemala, where a rural development NGO working with indigenous populations reports that 32% of new users adopt SDM.

Of note, SDM attracts many first time users of family planning. Studies have shown that 30% or more SDM users were first time FP users while a similar percentage had discontinued another method in the past. Rwanda is an exception: only 4% of SDM users had used any other method. In India, of the total 1868 users, 520 had used a method previously, but almost all had not used any method for at least 2 months before adopting SDM. The small minority that switched from another method directly to SDM may be responding to the broader method choice available and dissatisfaction with the previous method used. These data should reassure program managers and decision makers who worry that offering FAM would lead to large-scale abandonment of other modern methods by current users.

Regarding the use of condoms during fertile times: in Rwanda, 661 (18%) of the 3660 users used condoms; 286 of them received services in MOH facilities and interestingly, the second largest provider group was FBOs. This level is particularly noteworthy in a country where condom prevalence is under 1% per the latest DHS. In India, 68% of rural couples abstained and 32% used condoms while in urban settings, only 2% abstained. In the Philippines, these figures were 70% abstinence and 30% condom use.

Continuation rates for women who entered the long-term follow-up studies for SDM compare favorably with that of other methods: in long term follow-up studies, 42% of users in Ecuador were still using the method after 2 years and in India, 67% women who participated in the follow-up study continued use for 1 year or longer; the primary reason for discontinuation was the desire to become pregnant while 4% discontinued because they or their partner did not like the method.

Mainstreaming FAM into Programs

IRH's wall poster on research to practice demonstrates that the process of mainstreaming is accelerating as evidenced by the growing numbers of partners, countries, policies, etc. In addition to the previously discussed partnerships that IRH has achieved, critical components of this success include:

- Developing and disseminating the evidence base to convince groups that (1) there is a place for all FP methods, (2) broadening choices leads to increased number of FP users and helps women and couples achieve their fertility desires, and (3) FAM do not threaten use of other modern methods by encouraging irrational method switching.
- Building capacity in USAID, CAs, PVO/NGOs and Ministries of Health with TA assistance in planning, training, monitoring and providing tools.
- Creating champions and neutralizing antagonists within partner organizations in the process of training, research and TA.

Results of the Research to Practice process are not uniform in all settings. In the best of cases(e.g. Peru), SDM is included in FP programs and is available in a broad variety of public and private service delivery agencies. It is found in official norms and practice guidelines, enjoys validation as a modern method by professional organizations, has achieved inclusion in pre-service, in-service and community provider training and CycleBeads are included in the logistics system. Some agencies, which received CB stocks, are replenishing them with their own non-USAID program funds and include cost-recovery efforts in their sale to users. In addition, SDM is in the MIS, a critical element in monitoring user acceptance. At the opposite end of the spectrum, reproductive health decision makers may just be beginning to consider SDM as a possible addition to programs.

Despite impressive achievements, in no country to date is SDM mainstreamed and broadly available in urban and rural services aimed at an entire population. This is not surprising given the short life span of the AWARENESS project. Applying lessons learned in the Scale-up and Impact studies now underway in restricted areas in Rwanda, Peru and India, there are opportunities for the final project year and the follow-on project to assist large scale-up in some specific settings. In Rwanda, SDM has been mainstreamed in sites in which studies have taken place and is now ready for mainstreaming through the Twubakame and Capacity bilateral projects, managed by IntraHealth, which are expanding FP to new provinces and whose staff, in the former case, have been trained by IRH to introduce SDM. The next challenge here is to calibrate IRH's 2-day training module for SDM into their broader training program for FP providers, which currently allocates only 2 hours for SDM. The organizations need and plan to work together to find a middle ground on the minimum effective time needed to train providers

to provide SDM. In India, Jharkhand State will initiate the training of 50,000 new community workers (Ashas) in family planning and SDM will be included in this effort. (See India report in Appendix 9).

There is still a great need to move forward in capacity building. If there is a broad scaling-up effort, this will necessarily strengthen country/state capacity by stimulating new coalitions and partnerships and incorporating new actors. IRH consultants have stated that this is one of the most important objectives for a follow-on project.

No site is considered sustainable yet by IRH, in terms of FAM. Some countries may be reaching a tipping point (e.g., DRC) but IRH strongly feels - and lessons learned from other experience reinforce - that support from a dedicated project needs to be continued for a period of years. IRH can also use other strategies to advance sustainability including increasing South-to-South TA by IRH staff and selected consultants, and the establishment of regional training centers; CEDPA, in India is now in process of supporting the establishment of such centers, managed by large local NGOs in 3 states.

Unexpected Results of the Research-to-Practice Effort

The most noteworthy is the great degree to which IRH has accomplished its multiple and sometimes complex tasks in the short time elapsed since project initiation. There are, in addition, some unforeseen results/situations. Some of these are positive, such as that providers have become more comfortable addressing condom use; the IRH training strategy on condom use has resulted in a request for assistance in Central America STI/HIV programs. Another positive outcome has been the establishment of new NGOs, independent of IRH, that work on FAM issues, such as ISR/Peru and IRH/Philippines. The IRH/P representative stated that having IRH/US leave the country forced the local NGO to sustain activities with IRH moral support and sharing, modest funding from UNFPA and Packard Foundation, support by key official agencies (the Philippine Council on Research and the GOP Ethics Board of the Department of Science and Technology), and cooperation from decentralized provincial MOHs and a variety of local development NGOs. The informant concluded that IRH could, as a sustainability issue, adopt a policy of stimulating local or regional independent NGOs to extend its reach and advance sustainability.

An example of mixed results is with CARE in India: CARE conducted a study to introduce SDM in rural villages in Uttar Pradesh. When the study ended, CARE withdrew from the study area and informants state that SDM is no longer available in the 54 villages where it had been introduced. CARE will collaborate with IRH in Jharkhand State but has requested that IRH provide significant TA for their training of trainers.

Men's Involvement

Some degree of men's involvement/cooperation is a prerequisite for SDM use; to date, IRH has done some analysis of this and other gender-related issues. They have demonstrated that most men are interested in the method and many of them wish to be active participants in keeping track of their partners' fertile days. Some men prefer this method because of concerns with their partners' health and avoidance of side effects attributed to other methods. On the other hand, men can also be gatekeepers who decide couple should discontinue the method because they

dislike abstinence or condom use. Men have been found to be able FAM educators and providers particularly when educating men and couples. Also, positioning condom use as an alternative to abstinence helps defuse the perception of condoms as related to unfaithfulness.

There is still need for more systematic study of gender issues and FAM to determine what motivates men in encouraging or discouraging FAM use, and to document if men's involvement positively (or negatively) impacts women's health, autonomy and self-determination (see research agenda in recommendations section).

C. Scaling up SDM

Potential

SDM is poised for scaling-up and it is now necessary to focus on achieving critical mass in selected countries to demonstrate population-based impact and to learn from this experience. IRH has identified Guatemala, Benin, DR Congo, India, Peru and Rwanda as settings with high-potential for scaling-up.

Certain conditions may create a more favorable environment for mainstreaming FAM in services to large populations:

- New comprehensive FP initiatives
- Established productive partnerships with public and private agencies, CAs, NGOs, PVOs
- Desire of the MOH to add FAM to available choices and inclusion into national norms and guidelines
- USAID agreement and, ideally, support
- Existing infrastructure and capacity which can be expanded
- MIS includes or plans to include FAM to monitor achievements (and DHS and other population-based surveys will add questions leading to measurement of SDM, TDM and LAM use in order to document its impact).

In addition, FAM may be a particularly appealing or feasible method for some populations or settings:

- Fragile states/countries with low CPR
- Isolated, distant populations with poor access to services
- Traditional, indigenous, tribal populations
- Refugees and mobile populations
- Significant numbers of women/couples who are reluctant to use other modern FP methods and/or using NFP and other traditional methods ineffectively
- Settings with low HIV/AIDS prevalence

Important questions for study during broad mainstreaming and scale-up include:

- Conditions/determinants for SDM scale-up

- Threshold financial investment for mainstreaming in different settings
- Additional service delivery mechanisms (e.g., other community worker categories, FBO teachers, micro-credit groups, new social marketing strategies)
- Alternative training and client education approaches (e.g. distance education, group education followed by short person-to-person counseling)
- Lower cost product (CB) procurement, or easier to produce locally

To educate the community and create demand for FAM, use of mass media and other communication approaches should be expanded when scaling up, including cost-effective IEC strategies using data on people's preferences and access to media from existing or new studies.

Radio is one high potential vehicle, as it is an important source of information and entertainment in developing countries; is relatively low cost and has been used worldwide to educate on a variety of health-related topics. IRH has not yet taken full advantage of radio to avoid generating demand where SDM is not available. When scale-up to larger populations is under way, radio may play an important part: soap operas, spots and talk shows can reach a wide listening audience and appeal to both men and women. Examples of the use of radio by IRH include: in Rwanda, a radio talk show has been done on FAM and discussions are underway to include an ongoing story line in the most popular soap opera in the country, which is listened to by 65% of the population. In Guatemala, during an IEC campaign, a 30 second spot in which a couple was discussing their relationship and child bearing, there was an anecdotal report that more men were attending with their wives to request SDM. As part of social marketing studies radio-based campaigns have been used but continuous brief spots have not been tested.

Challenges for FAM Utilization and Scale-up

Scale-up efforts will necessitate a change from responsive yet multiple, scattered TA efforts to a focus on chosen scale-up sites, partnering with key local actors, applying what IRH has learned and studying what is yet not known. Challenges to achieving this level of scaling up will vary from site to site and must be addressed through sufficient funding, strategic thinking, testing of different models as well as greatly gearing up dissemination/IEC, training, material development, adaptation and distribution, quality improvements and other efforts.

Clinical providers are one of the principal challenges to FAM scale-up because they may, if not involved from the beginning, discredit the methods; as one physician reported you can't leave the medical community out or they will be disparaging and a barrier to wider acceptance of the method as "modern." Figuring out appropriate roles and relationships between non-clinical and clinical providers to expand access will be conditioned by the countries' service infrastructure as well as cultural factors which may preclude certain options that have been identified as best practices in other settings.

Another challenge is the need to integrate SDM into multi-method provider training. As this is still a new method, most health professionals have not been exposed to it, much less had training in its delivery. Additionally many hold biases based on views of traditional NFP as ineffective. SDM training can take relatively greater time because it must include contents not found in other

method modules (menstrual cycle and fertility) and because people are unfamiliar with it. Strategies will have to be directed at trying to reduce SDM training time to better fit in with multiple method training while preserving essential knowledge for effective provision. In addition, training needs to prepare providers to overcome difficulties many have in discussing sexuality, such as the need to refrain from unprotected vaginal intercourse during fertile times.

The perceived time required for counseling may also be a barrier to scaling up; it is perceived as problematic by clinicians, who have many competing demands and prefer not to spend their time on counseling. IRH estimates that 20 to 30 minutes are sufficient to teach a woman SDM use; this time is not longer than what is needed to teach a first time user/woman how to use other methods (condoms, OC, etc) if correctly done. In community-based services, time for teaching the method may not be a barrier because providers are more likely to have time to inform and counsel; in clinical services, very busy providers may shortchange SDM and other method counseling alike.

Misperceptions about FAM held by many providers, USAID and CA staff have also been identified as potential challenges. Biases include: FAM are not effective; they are only appropriate for highly religious individuals and FBOs; they will siphon off potential or current users of other modern methods which are perceived as more effective; they are not appropriate in many countries with high HIV rates; illiterate women do not have the capacity to learn and use the method correctly. Providers also believe that many couples (especially men) cannot or will not practice the alternatives required during the woman's fertile period (abstinence, condoms or alternative forms of sexual expression). As one pro-SDM doctor in Haiti commented: "some believe that men can't be abstinent and can't 'control themselves.'" We found that even some supporters of SDM (e.g. within Missions which have provided funding or among USAID/W staff), harbor views that SDM is second best to other effective methods.

Funding is perhaps the most important barrier to extensive scale-up: many USAID Missions do not consider field support necessary because IRH is considered a research organization and they do not necessarily see how FAM can, not only, benefit women/couples but also further Mission goals and IRs by reducing unmet need and increasing FP use.

Strategies to Address These Challenges

IRH has made assiduous efforts to broadly position FAM, via SDM by disseminating the results of its research through many fora and media, presenting accurate, updated information about SDM and countering outdated information or views. A number of informants have commented on IRH effectiveness in communicating to multiple audiences to create new awareness about FAM.

The development of CycleBeads has also promoted the concept of SDM as a new method and has generated some 'buzz' to further position NFP. It remains to be seen if alternative, less attention getting aids can also serve this function.

Regarding barriers to service delivery (reliance on CB as an essential commodity for effective SDM use and training and counseling time) IRH is undertaking research to look at alternatives to CB and the least time-intensive ways to train providers to counsel effectively and monitor and evaluate results.

In the future, IRH needs to build on its already robust communication strategies to convert 'nonbelievers' to SDM. Many of the communication strategies employed to date have been to disseminate research results in peer-reviewed journals, through respected global and regional health fora (e.g. APHA, the regional repositioning family planning meeting in West Africa), organizations (e.g. WHO) and interagency mechanisms (e.g. Implementing Best Practices). IRH deserves significant credit for proactively leveraging opportunities to communicate to a wide variety of audiences about SDM.

Going forward, we recommend that IRH increase the promotion of SDM inclusion to key provider and donor audiences via user-friendly approaches, such as one page "leave behind" bulletins highlighting research results which clearly relate to specific country needs and addressing common misperceptions. (See Appendix 11 sample bulletin). Marketing to USAID Missions will be especially important in the scale-up phase, given the importance of bilateral funding mechanisms and to encourage mainstreaming of SDM. HPN staff are increasingly generalists and exceedingly busy, and thus less likely to read long briefings, journals or to attend technical meetings. Prioritizing message development tailored to these audiences and strategic marketing and outreach, is vital. USAID/W can be an important influence in this effort. IRH will also need to increase staff time devoted to strategize and leverage non-USAID funds to be used in scaling-up by aggressive communication and visits to potentially interested funders.

D. Project Management

Management, Staffing, and Administrative Systems

IRH has achieved progress with a lean, highly competent staff. Staff at headquarters and in country offices universally won high marks for their professionalism, dedication, credibility and responsiveness. The project director has a reputation for exceptional communication skills, effective collaboration with USAID/Washington, WHO, CAs and other partners and for seeking and taking maximum advantage of opportunities to present and introduce SDM. Staff, and the director in particular, are perceived as maintaining dialogue with a broad range of actors involved in NFP from across the political and ideological spectrums, and deftly positioning FAM within the range of contraceptive options--including discussion of all options, and provision of condoms or emergency contraception--while also working with those favoring traditional, abstinence-only approaches to NFP.

The IRH staff is lean and cohesive. Twenty three of its staff are in HQ and a small number in its field offices. The management structure and small staff size have facilitated execution of the cooperative agreement because there is little internal bureaucracy and a high level of staff knowledge about the work of other programs and colleagues. The cross-training of staff--for example so that researchers can do training and program staff can assist with research--and matrix-management structure strengthen institutionalization of knowledge and capability. As the project has expanded in recent years and

presented more unplanned opportunities to introduce SDM, staff have taken on additional responsibilities and may be stretched thin. The polyvalent nature of staff roles and IRH's extreme responsiveness to expressions of interest in SDM, also encouraged by the USAID/W TA, sometimes has caused ad hoc assignments to trump work in the pipeline, distracting from primary responsibilities and causing delays in on-going priority work; a concrete example is the added responsibilities of the Director of Behavioral and Operations Research as the India country monitor and as trainer.

IRH has attracted and retained excellent staff, both in its Washington headquarters and in its country offices. Staff exhibit great dedication and staff turnover has been very low over the project period, which speaks to their interest and commitment to the project and to the positive working environment created by senior managers. IRH's affiliation with Georgetown University provides its employees with attractive benefits, especially related to continuing education.

IRH has the necessary skills to address issues under the current cooperative agreement, albeit with some overextension of staff. To accomplish goals suggested in a future project, it will be important to have additional skills in scaling up services within health systems, and in marketing to key stakeholder audiences. The former could be brought in through partnerships with other agencies specialized in service delivery. In addition, in the future project, it will be important for the project director and possibly the program director to devote increased time to raising funds from USAID Missions, and non-USAID sources.

In the future, we recommend that IRH re-structure and use staff to reinforce its functional dedication, e.g. one cluster focused on research and another on technical assistance and training for program implementation. Other ways to extend staff capacity are to increase the use of country-based staff to provide technical assistance, to train, or to represent IRH elsewhere in their region (or potentially in other regions, particularly where their language or program experience is a good match) and to further develop a cadre of consultants from the global South for the same purposes.

Given the strengths of country-based staff and to free up the time of DC staff, decentralizing responsibility should be a goal, focusing on increased autonomy of country-based staff with less day-to-day communication and problem-solving by DC supervisors.

Regarding administrative systems, because the University structure and approval system is deliberate and could potentially slow down procurement and other processes, IRH has contracted with the Development Group to more expeditiously manage travel, administrative and contracting of entry-level staff and consultants and other administrative functions on a lower cost basis than would be the case with Georgetown's overhead rate.

While IRH is very organized and well managed, its policies and administrative systems have not all kept pace as its operations have become much more complex. Whereas it was not a subcontractor or partner on any other projects in 2001, it is now part of several including: PASMO, ESD, EngenderHealth/Bolivia, PSI/Nigeria, SARA, SanteNet and Chemonics/Madagascar. The number of countries it is working in and of materials it has produced and disseminated have all mushroomed. To address these increased responsibilities, IRH is upgrading its financial, administrative, and field operations policies and procedures to

respond to the needs of different 'customers' and contexts. Specific areas where improvements were suggested by informants include speedier invoicing of agencies to whom it is a subcontractor, and personnel policies for field staff on issues such as health insurance. Other CAs with significant experience with field offices could provide operations manuals from which to adapt.

Part of the outlined research and scale-up agenda includes determining the costs associated with mainstreaming SDM, and potentially TDM and LAM. IRH will need to ensure its financial systems can track its investments of human and other resources in ways that enable such analyses. The current systems are not set up to disaggregate level of effort by country or program intervention (training, research, program scale up, etc.)

Relationships with USAID

IRH has an excellent and highly collaborative relationship with USAID/W, particularly in the RTU Division. There is frequent communication and consultation and research ideas are discussed early to assess their value, and if promising, to further conceptualize the design. USAID/W provides timely input and approvals for IRH initiated research, travel or other requests.

RTU staff, notably the division chief and IRH's TA, are seen as active supporters and wise counsel. Its TA is an strong advocate for FAM and for IRH and has been very effective at catalyzing opportunities and enlisting other champions within the RTU and elsewhere in the Office of Population; for example, the Director of the Office of Population has done important outreach on FAM within the Office and to specific Missions.

IRH has a mixed history with Missions; it has been welcomed in most but IRH activities have been mainly core funded because it is viewed as a research project. USAID Missions where IRH has introduced SDM have positive views of its work and of the professionalism and responsiveness of both in country and HQ staff. In some cases, because of recent changes in Mission personnel or responsibilities for project oversight, they were not very familiar with the specifics of IRH's in-country work and some Missions are uninterested or resistant to FAM for reasons that have been addressed elsewhere in this report. Even some Mission supporters hold a view that SDM is a niche method with a narrow bandwidth of potential clients. In a couple of cases—including in settings with characteristics suggesting good potential for SDM (Philippines, El Salvador, Bolivia)--IRH was asked to discontinue program support due to "administrative burden".

USAID/W needs to continue outreach through SOTA trainings, orientation of new hires, and communication during visits. IRH, in turn, needs to use very 'customer-oriented' ways to update USAID Missions (and others) on highlights of interest to them; e.g. how FAM has the potential to address the needs of populations of meaningful size, especially in low CPR countries and presenting short case studies of successful approaches to and successes in situations that are similar to the Missions' own.

IRH has been very active in several of USAID's global leadership priorities, notably MAQ, IBP, and Repositioning Family Planning. Through IRH's active participation in these fora, it has provided ongoing information and updates to a host of CAs, other important agencies such as WHO, and USAID staff. The Repositioning Family Planning initiative offers particular promise going forward, for example in Madagascar, as IRH's work relates very directly to repositioning FAM as more than NFP.

While IRH earlier participated in the gender-working group, there has not been active participation since the working group was restructured a few years ago. Given that FAM are methods where men's support is important, and where there are other interesting gender dimensions to explore (e.g. does condom use or reputation change; are there other effects on couple's sexual health behavior) or expand (e.g. men community workers providing the method), we recommend that IRH reconnect with the gender working group to share information about its findings and to explore potential collaboration (or even funding) on additional work to be explored.

Funding

Funding for the first five years of the AWARENESS project was $12,689,621 and was expected to be $15,000,000 for the second five-year period. With the development and significant promise of the SDM early in the second period, however, the ceiling was raised by an additional $15 million, raising the ceiling to $42,689,621 for the 10-year period. The total funding expected through May 2007 is $40 million, shy of the ceiling due to budget constraints at USAID/W but still significantly higher than the original projection.

The trends in funding reflect project achievements and anticipated opportunities to galvanize interest in SDM. Without such significant core funding from USAID/W, which was utilized not only to advance research, but also to launch SDM in pivotal countries, to create training materials and spur communications efforts, it is virtually certain that SDM would not have gained the momentum it has. This trend is also seen in the allocation of resources across IRH's IRs. In 2002, IRH estimates that 85% of its funding was dedicated to IR2 with no funds dedicated to IR3, whereas this year, it expects to allocate 30% of its funding to IR3 and 54% to IR2. Expenditures for IR1 have been consistent throughout the project period, at approximately 15%. (See Appendix #1: IRH Results Framework)

Going forward, as IRH updates its financial systems, it would be helpful to attribute and track expenses by IR and by country to facilitate future analyses of level of effort and results. For example, it would be useful to assess the costs and effects of providing technical assistance across its country priorities, to develop a firmer sense of the core investment required to make SDM "stick".

IRH's funding to date is primarily comprised of core funding from USAID/W, a pattern that is not unusual for projects within the RTU. Since July 2002, IRH has attracted field support from five USAID Missions totaling $1,984,321 or 7.5% of all IRH's USAID funding ($26,334,321) during this period. The core funding levels from USAID/W increased sharply in 2002 in

response to the promise of SDM given its efficacy research results and opportunities for country introductions to test experience. Funding has remained relatively level since then, with an expected dip this year as both a reflection that this is the project's last year and research efforts are winding down, as well as reduced levels of core funding within the Office of Population overall. A USAID/W staff stated: "They have used resources very well, absorbed four times as much as originally planned."

Raising funds from USAID Missions has been challenging for a host of reasons including outdated perceptions or skepticism about modern FAM; misapprehensions that FAM is related to the US government's broader faith-based initiatives and may be ideologically motivated; the move by Missions to consolidate their portfolios and reduce management burdens through reliance on fewer RH/FP contracts as well as the view that as IRH is in RTU, its costs should be covered by core funds. It is important for Missions to understand the full costs of funding the SDM programs in their countries, even if they only contribute a share.

IRH has had little success in attracting non-USAID funds to date. UNFPA has covered the costs of CycleBeads in Honduras and Nicaragua, and IRH recently won a grant for work in the US to introduce SDM in Planned Parenthood, San Diego. Also recently, IRH has won a 1.1 million dollar grant to improve VCT/STI counseling and services through improved and simplified training and job aids.

For some foundations, the same barriers may exist that constrain getting funding from USAID Missions: the perception that FAM is not an effective modern method and that other significant funding is available for what appears to be a faith-based (or approved) method, lack of awareness of potential market for this method, disinterest in funding method-specific proposals etc. Many foundations, including some IRH has approached and been turned down for funding, have an outdated perception of FAM. We believe that aggressive outreach to other institutional donors—both private foundations and other bilateral agencies (e.g. DFID, KFW), is important not just to pursue funding but also to raise the profile of IRH and FAM with these organizations, potentially important sources of influence and information, even when they are not providing funding. For this reason, IRH should approach foundations such as Packard, Macarthur, and Hewlett because they are influential actors in the FP/RH sphere. Concrete recommendations to do so include making a presentation on SDM at a Funders' Network on Reproductive Health semi-annual meeting, and meeting with key donors where they are clustered (e.g. Northern California for Compton, Hewlett, Packard, Bergstrom; Western Europe for key bilaterals). The pitch to new donors should focus on elements of the IRH agenda that align with their priorities or possible interest, e.g. the effects of providing emergency contraception with CycleBeads, or gender dimensions of FAM.

III. Recommendations

On the basis of the substantial research agenda yet to be accomplished, opportunities to scale up broadly and understand the required conditions for successful scale-up of FAM, the need for continued attention to sustainability issues, and the potential to reach/serve populations which may chose FAM over other methods (or no method), we strongly recommend that USAID fund a follow-on project

focused on FAM and LAM. In order to achieve the important yet ambitious goals outlined below, it will be critical to prioritize opportunities and needs, to ever more strategically deploy resources and to aggressively seek and attract funding in addition to USAID core funds. The follow-on project should concentrate its TA and OR efforts on solidifying accomplishments, applying lessons learned and institutionalizing the work to date to ensure a sustainable inclusion of the SDM in country programs and to make research-based recommendations to improve the use of TDM and LAM.

A. Future Research Agenda

SDM

- Identify the preconditions and determinants of successful scale-up and assess the threshold level of investment required for its country-specific mainstreaming.
- Conduct long-term follow-up of current SDM users to better understand their contraceptive behaviors: compare method continuation, switching, and abandonment behaviors with users of other methods.
- Determine if adding SDM to available method choices leads to increased use of other methods as suggested by trends in previous research.
- Seek lower cost, locally produced alternatives such as the paper image CycleBeads and test their appropriateness in different countries.
- Study additional demand creation and service delivery mechanisms such as new social marketing approaches and service outlets (e.g., micro-credit groups offering other health services), use of lay community workers, expanded FBO outreach. This will require more formalized partnerships with social marketing organizations.
- Determine if adopting SDM as a first method changes some women's perception from a fatalistic and powerless view of their ability to plan their family to an understanding that they have that option; if so, how many of them switch from SDM to other modern methods?

TDM

Many studies undertaken on SDM need to be replicated for TDM and should lead to evidence-based decisions on its potential for broad introduction in multi-method programs. Among them:

- Test provider training strategies for the delivery of TDM by professionals and community workers; develop job and user aids to facilitate teaching and using TDM; determine if TDM can be delivered with the same level of quality as SDM with similar provider qualifications and similar training resources.
- Test ways to offer the SDM and TDM simultaneously avoiding provider confusion and reduction in service quality.
- Study the relative uptake and the determinants of women's choice if SDM and TDM are offered simultaneously
- When studies are complete, initiate scaling up TDM to larger populations if findings warrant "green lighting."

All FA Methods:

- Conduct research to understand how FAM can meet the needs of special populations (e.g., tribal and indigenous groups, refugees and migrant populations) and be introduced in particular settings (e.g. rural areas and fragile states) for which it may be especially well suited.
- Conduct systematic studies on FAM gender-related issues: strategies to increase men's awareness, interest and participation in FAM and willingness to use condoms if not abstaining during the fertile period. Endeavor to understand if FAM use leads to changes in women's sense of empowerment, and if it is positively or negatively associated with women's health, sexual violence and couple communication. Conduct research on whether partner participation in FAM counseling and method selection increases or decreases continuation and/or unintended pregnancy rates.
- Experiment with and assess training approaches including non-traditional approaches such as distance learning (e.g., MSH's blended learning program and India's NGO- URMUL's satellite broadcast training) for different levels of providers to determine most effective approaches to integrating FAM into existing training programs.

LAM

LAM, developed and tested by IRH, has most recently been housed in the LINKAGES project, now in its final stage; informants from countries where LINKAGES had not been active (e.g.Guatemala, Honduras, Philippines) have commented that LAM, which had been incorporated into FP programs, has shifted to an incorrect and more laissez-faire and incomplete message: "breastfeed and you won't get pregnant." The LAM experience may serve as a valuable lesson learned on the risk of retiring dedicated projects before they are fully institutionalized and deemed sustainable. With the imminent ending of LINKAGES, USAID has requested IRH to re-incorporate LAM in its scope of work, with additional dedicated funding, for the remainder of this project. USAID's reasons are its interest in continued support for postpartum family planning and the continued need to help LAM become institutionalized and mainstreamed as a modern postpartum method. There are also opportunities to work with ACCESS/FP on LAM within postpartum service delivery

LAM research priorities include:

- Repositioning LAM to assure proper use and firm institutionalization
- Understanding the determinants of the noted erosion to prevent losing additional ground
- Testing ways to simplify teaching and provider training of the LAM criteria to clients and providers to ensure correct use

Additional research needs should be defined through discussions with key players with substantial interest in postpartum family planning (e.g. FHI, Population Council, ACCESS/FP) and as well as LINKAGES staff.

Research on a Bridging Method Between LAM and FAM

Is there a practical, simple, bridging method for postpartum women to initiate FAM?

An important number of women in countries where long-term breastfeeding is common will be protected by LAM for up to 6 months, but will not resume cycles for some time; a number of them become pregnant before menstruation is reestablished on a regular basis. As this group cannot be protected by SDM or TDM, IRH has developed a bio-statistically calculated process to reduce these unwanted pregnancies. Tests with 200 women have shown that they were able to follow the protocol. However, the women had monthly follow-up (for data collection) and were required to return to the provider at least twice for the required sequential instructions. This protocol is intuitively impractical, complicated and labor-intensive and, in addition, has not undergone an efficacy trial, thus preventing IRH from calling it a method. If funds are available, IRH should continue exploring the development of a bridging method with less intensive requirements for the prolonged postpartum period.

B. Scale-up

The follow-on project needs to focus on several strategically selected nationwide scale-up initiatives to fully demonstrate how FAM can be incorporated in broad, multi-method programs. There are a number of countries in which IRH has worked that are (or soon will be) ready for such an initiative. In India, such scale-up should be tried at the state level. This would involve the selection of two USAID Mission's priority states: Jharkhand, which could serve as a learning laboratory for Uttar Pradesh to scale up one or two years later.

In order to scale up FAM, IRH and USAID/Washington need to engage a number of other actors to mobilize the necessary funding and political will, to overcome resistance to or ignorance about FAM, and to foster the needed capacities in national systems for FAM to be mainstreamed and positioned for sustainability. One of the end goals of a possible follow-on project would be to establish training, supervisory, monitoring/MIS and logistical capacity in the selected scale-up sites so FAM becomes integrated and needs no further IRH inputs.

<u>Priorities for Achieving Sustainable Scale-up:</u>

1) Learn from scaling up in selected sites and broadly disseminate lessons learned to partner agencies, CAs, PVOs and FBOs. With IRH materials and CB logistics, such groups may then be able to integrate FAM into their programs in other countries with minimal or no IRH support.

2) Further position FAM to influentials as effective, desirable modern methods by:

   - Crystallizing key messages to promote SDM to USAID Missions and CAs, emphasizing its benefits in achieving *their* objectives: attracting new FP users, increasing CPR, decreasing unmet need for FP, involving FBOs, involving men while possibly also normalizing condom use. Describe its collateral benefits, among them: ability to bring together FP providers who otherwise have not found common cause (e.g. traditional NFP providers and social marketers); facilitation of condom use introduction in faithful relationships vs. for RTI prevention.

- Distilling AWARENESS research findings for consumption by busy program-oriented skeptics. Develop short case studies and position papers on SDM's successful introduction in key countries (e.g. using impact study findings) and describe its potential, particularly in challenging settings (fragile states, low CPR, strong religious settings);
- Continuing to position SDM, TDM and LAM as modern methods, including on DHS surveys;
- Proactively informing and enlisting important stakeholders, including from outside the USAID/CA sphere (e.g. the feminist community), who may become additional allies and champions of SDM, rather than opponents;
- Finalizing the most user-friendly name for FAM (vs. NFP) and using it systematically;
- Organizing one or more meetings to share knowledge and address challenges and solutions on methods at both ends of the contraceptive spectrum that tend to be underutilized and sometimes seen as controversial, (such as FAM and long term/permanent methods). This kind of meeting (or the AWARENESS end-of-project meeting) could be valuable for Africa, given the low CPR and potential for FAM as well as long term and permanent methods.

3) Engage CAs, NGOs, FBOs and other international agencies experienced in scale up of FP into established health service systems.

- Seek opportunities for collaboration with CAs and PVOs willing to invest funds or cost-share.
- Identify and cultivate champions within all partners.
- Pursue and join teams bidding on broad-scale bilateral reproductive health and FP procurements in strategic scale-up countries.

4) Build Capacity and Mainstream FAM in Country Programs

- Increase involvement by a range of community workers and supportive religious institutions in raising awareness of and expanding access to FAM.
- Integrate FAM and LAM in pre-service FP training of physicians, nurses, auxiliary nurses, professional midwives.
- Involve health professionals to legitimize, but continue to avoid medicalization of FAM.
- Address provider barriers to method, e.g. concerns about amount of time for counseling, and focus on positives such as one-time nature of the method, no need for ongoing user re-supply, etc.
- Increase use of South-to-South TA and training, maximizing the use of country-based IRH staff and proven consultants and by establishing regional training centers and CB distributors.

5) Create Demand for FAM Among Potential Users

- Increase the use of popular media approaches: posters in communities, street theater, radio ads, soap opera, FAM branded items (tee shirts, caps, bags) carried or worn by community workers (would also are inexpensive 'rewards' for their work).

- Promote SDM as an effective way to increase birth interval and as a means to delay first pregnancy, especially in traditional societies with culturally determined early marriage and closely spaced births.

6) Broaden Funding Base and Support

- Conduct strong outreach and marketing to USAID missions on a strategic basis. Show how SDM will help Missions accomplish their goals.
- Carry out future core funded introduction pilot projects only with explicit Mission commitment to invest field support funds if the strategy proves effective.
- Market to private foundations, key European bilaterals, and other donors and important stakeholders, to raise awareness of FAM and its FP/RH benefits when broadly integrated into programs, as a necessary prelude to seeking funding. Develop selected proposals related to specific elements of the IRH agenda that also fit interests of particular donors.

7) USAID/Washington

- Arrange to include CB in USAID commodities list and encourage UNFPA to include CB in their commodities list. In the short term, continue to inform USAID/W and Mission staff about the waiver for low volume acquisition of CycleBeads at the public sector price and urge Missions to inform country programs of pricing as well as purchasing procedures.
- Continue to aggressively market FAM to USAID Missions.
- Include FAM as deliverables in all new FP procurements. CA evaluations should document FAM integration efforts and results in reporting on their broader FP programs.
- Facilitate or help broker selected countries where CAs can or should overlap with IRH and facilitate joint work planning and resource allocation.
- Provide funding and other support for IRH marketing/fund-raising travel to meet with other potential major donors.

8) IRH

- Staff should focus on their specializations to help avoid diffusion of efforts and unnecessary delays in achieving ambitious goals.
- Increase use of trainers and technical assistance experts from Southern countries for the latter work.
- Given the importance of communications and 'marketing', it would be advisable to hire a communications specialist in a future project.
- The Project Director and Director of Programs will need to devote increasing time to raising funds from USAID Missions in strategic countries and to other donor outreach.

<u>Future Project Structure and Location:</u>

The team asked many stakeholders, within the different divisions of USAID, IRH and CAs, about the need for and possible contours of a follow on project. There was strong support for a follow on project and most felt that some kind of focused effort on FAM was needed for

progress to be made on scaling up this method. The team heard divergent views on where a future project belongs within USAID/W.

After weighing the input and considering various options (see Appendix 12 for pros and cons of alternatives) we recommend a single source, non-competed follow-up project.

We recommend, as did numerous others, a future procurement project that is not competed because IRH is particularly well suited to provide the continuing need for global leadership on FAM. This conclusion is based on: IRH's predominant capability with respect to FAM; its demonstrated global leadership and research prowess in this area; and the value-added from its association with Georgetown University and IRH's location within its Medical Faculty which enhances its credibility and access to expertise. A number of those interviewed also stated that it is in the US Government's best interest to award a future FAM project on a sole source, non-competitive basis.

To maintain momentum and facilitate the possibility of attracting funding from other sources, we recommend that a follow-on project be designed to begin immediately following the project's current end date, if possible. If this is not possible, bridge funding is recommended.

Given the importance of the research and global leadership agenda, sufficient funding will be a critical element of future success. For this reason, we recommend that current core funding levels be increased, insofar as possible within the Office of Population's overall budget.

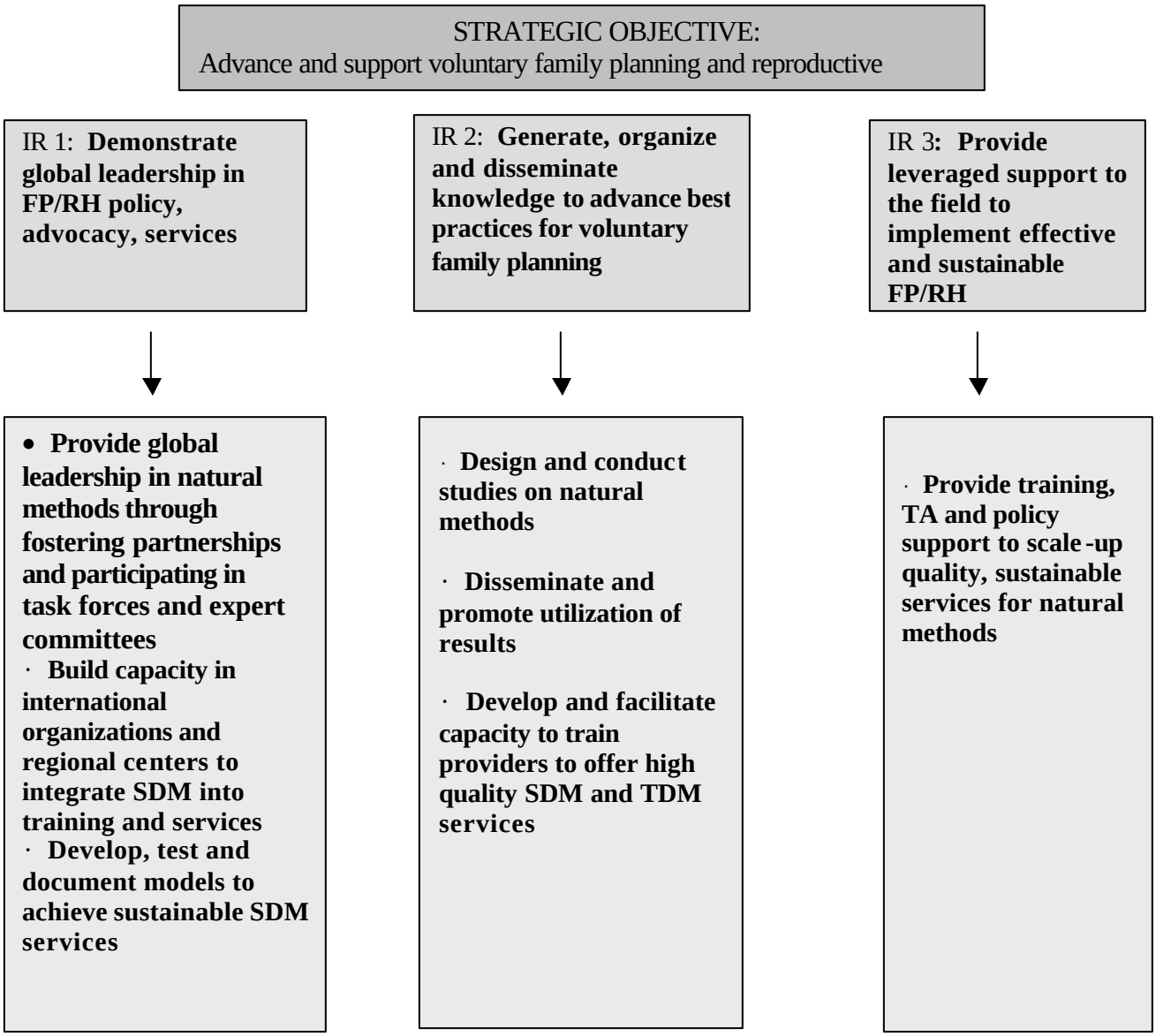
We recommend that the future project design focus on IRH as the main source for capacity, with a limited number of partners. Such a project design recognizes IRH's strong capacity and would help optimize rather than diffuse future core funding. Having a limited number of partners, especially with expertise on scaling up FP/RH services within health systems, could facilitate the goals of the future project by 'infecting' the involved partners with enthusiasm and knowledge about FAM, which could spread to others in their agencies. As importantly, it would complement IRH's capacity in areas where it will need deeper expertise to achieve the scale-up and mainstreaming agenda.

We recommend that this project be conceived of for a 6-8 year period given the ambitious agenda, the expectation of full transference from research to practice. The expected goal at the end of the project period would be to have FAM so integrated within USAID and country programs that a further dedicated project is not required.

We have an unorthodox recommendation for the placement of a future project, recognizing the importance of both its research and service delivery elements. Given the need for systematic learning as scale-up is being undertaken and for ongoing global leadership and technical assistance to position FAM, we believe that this project should continue within the RTU for its first phase. However, because the goal is mainstreaming FAM within broad FP services and health systems, we recommend that there be a planned transition to the SDI Division during the course of this project, e.g. in year 4 or 5. To facilitate this transition and ongoing mainstreaming in broader SDI projects, we recommend IRH staff sit in on SDI CA meetings while it is housed in the research division. The proposal to transfer the project from the RTU to SDI will result in better application of research in mainstream practice.

Appendices

Appendix 1
The AWARENESS Project Results Framework



Appendix 2
Statement of Work

EVALUATION OF THE NATURAL FAMILY PLANNING AND REPRODUCTIVE HEALTH AWARENESS PROJECT:
Reviewing Progress and Impact, and Making Recommendations for Future USAID Action

I. BACKGROUND

The Natural Family Planning and Reproductive Health Awareness Project (Awareness, 936-3088) is being implemented by Georgetown University's Institute for Reproductive Health (IRH) through a cooperative agreement with USAID (HRN-A-00-97-00011). This is a ten-year project that was authorized on July 7, 1997 with a PACD of May 31, 2007. The five-year cooperative agreement began on July 7, 1997 and was extended for the second five-year period to end on May 31, 2007. The project was authorized at a funding level of $42,687,621 for the ten-year period and $29,318,000 has been obligated to date into the cooperative agreement.

The Awareness project is responsible for the majority of USAID's natural family planning (NFP) portfolio. The goal of the cooperative agreement is to improve and expand natural family planning services and develop new strategies and approaches to increase reproductive health awareness of individuals and communities in developing countries. The project addresses the needs of people who use or would like to use a natural method to avoid pregnancy but lack the information and skills to do so effectively. The objectives of the agreement with illustrative activities are provided below:

5. Making simple NFP methods available
    - Develop and test new NFP methods
    - Provide and disseminate information on new NFP methods
6. Improving NFP service delivery systems
    - Increase capacity of governments and NGOs to provide NFP
7. Mainstreaming NFP into integrated reproductive health and other services
    - Incorporate NFP into existing FP/RH norms and guidelines at global and country levels
    - Operations research to test SDM introduction into FP/RH programs
    - Collaborate with service delivery and donor organizations on NFP
8. Incorporating reproductive health and fertility awareness (FA) into programs and services
    - Increase male involvement to increase couple communication and FP use
    - Integrate FA into existing FP programs

The Awareness project contributes specifically to the Global Health Bureau Strategic Objective number one (SO1) – advance and support voluntary family planning and reproductive health programs worldwide. All three Intermediate Results (IR) are addressed through this project: IR 1. global leadership exercised in FP/RH policy, advocacy, and services, IR 2. knowledge

generated, organized, and communicated to advance best practices, IR 3. support provided to the field to implement effective and sustainable FP/RH programs (see list of background documents).

Biomedical and operations research conducted by IRH has led to the development and piloting of a new, scientific, and very effective natural family planning method. This new method, the Standard Days Method (SDM), has received unprecedented support from the Office of Population and Reproductive Health (GH/PRH). The IRH has completed several operations research studies to understand the provision and use of the SDM in service delivery settings in developing countries. Three impact studies to understand the value of the SDM to family planning programs are currently underway in three countries. Overall, The success of the SDM has led to high demand for IRH technical assistance to USAID Missions, Ministries of Health, and the private sector (commercial, NGOs, FBOs, etc.) to introduce the method into their programs. In addition, another new NFP method, the TwoDay Method (TDM), has completed clinical trials and appears to have great potential for the field, while development of a method for postpartum women is in early pilot phase. Currently, operations research studies of the TDM are being implemented in several countries. These two methods have recently been included in WHO documents as modern methods and are gaining credibility and popularity in the field.

II. PURPOSE OF THE EVALUATION

The purpose of this evaluation is to assess the performance of the Awareness Project as the Global Health Bureau's premier NFP project and provide information to USAID for the design of a follow-on project. Specifically, the evaluation team would be expected to:

- Assess the performance of the Awareness Project relative to the goals and objectives of the cooperative agreement and the Office of PRH;
- Assess the impact of research findings, new methods developed, and capacity building activities on family planning and reproductive health programs worldwide;
- Provide guidance to USAID on the scope for a future project and mechanisms of funding.

III. EXISTING PERFORMANCE INFORMATION SOURCES

For this evaluation, the existing sources of information on the performance of the Awareness Project include: annual workplans and reports, interim reports, annual results reviews, periodic special reports, research reports, strategy documents, management reviews, and the report from an earlier external evaluation completed in 1994. These documents detail the activities of the project and describe issues related to implementation and their resolution. Additional information can be acquired by the Evaluation team through interviews with Awareness, USAID/W, Mission staff, other USAID cooperating agencies, other in-country stakeholders and field visits. The suggested relevant documents and interviewees are identified below.

IV. QUESTIONS TO BE ADDRESSED

The following are specific evaluation questions to be addressed by the team. Additional questions and issues may be added at the team's discretion. The Evaluation team, with RTU staff, should prioritize the questions to increase efficiency of the process.

A. Research Results and Program Impact

1. Research Results

a. To what extent has IRH successfully achieved the project results outlined in their Results Framework (Attachment 1)?
b. What unexpected results, positive and negative, have been achieved that were not originally projected in the Cooperative Agreement?
c. What gaps, if any, exist in their research agenda? Please outline any major questions that remain to be answered regarding the new NFP methods and their use in programs.

2. Program Impact

1. What is the process that IRH follows to disseminate research findings and ensure utilization of information and new methods developed? How well is the process functioning?
2. How effectively does IRH work with other research and service delivery CAs, Ministries of Health, and other FP and NFP organizations to implement studies and utilize research findings internationally and in developing countries? Please identify specific examples of collaboration.
3. How effective has IRH been in moving NFP from "research to practice" To what degree has NFP been mainstreamed into FP/RH programs and services? Please identify specific examples of capacity built in international and developing country organizations to provide NFP and please provide an estimate of the numbers of users of the SDM and TDM worldwide.
4. At the service delivery level, do any challenges exist for NFP utilization and scale-up? At the headquarters, national and mission levels, what challenges exist for NFP integration into FP programs? What steps have been and should be taken to address the above challenges?
5. Although the SDM is a natural method and, therefore, not dependant on any contraceptive commodities, the method is closely associated with the Cycle Beads teaching tool. How dependent are clients and programs on the Cycle Beads? What are some of the challenges facing programs in procuring these beads or manufacturing them locally and what should be USAID's position regarding this tool and future expansion of the method?

A. Management and Financial Issues

1. Management

a. How does the current management structure and administrative system enhance or inhibit the implementation of the cooperative agreement? Are project resources and activities being allocated to maximize efficiency and impact? In what ways, if any, should the structure and management processes be changed?
a. How efficient is IRH in developing research projects? How efficient is the approval process for implementing new studies? Is the time from concept development to field implementation reasonable? What, if any, process and management changes are needed to improve efficiency?
b. How successful has IRH been in recruiting and retaining staff well-suited to achieving the objectives of the cooperative agreement? Are there areas where additional staff is needed, or where a reduction in staff would be appropriate? How well does IRH use contract staff?
c. What are the strengths of the relationship between IRH and USAID (RTU, PRH, GH, Regional Bureaus and field Missions) and how can the relationship be improved? What are the strengths of the relationship between IRH and the project management team and how can the relationship be improved?

a. Funding issues

a. How does the funding allocation within IRH relate to the objectives of the cooperative agreement? How appropriate are the decisions that have been made when budgets had to be reduced or increased?
b. To what degree have USAID funds been used as seed money to attract other funds including support from other donors? What type of changes should occur, if any, to facilitate this process?
c. Do trends in funding appropriately reflect project achievements? To what extent have funding trends had an impact on IRH management?

B. Future Directions

1. Are major changes needed to the overall objectives of the current program? If so, in which areas, and to what extent?
2. What are the future research initiatives that should receive priority attention, and what, if any, barriers to progress will need to be addressed within a new program?
3. What is the capacity of the project to incorporate LAM into their existing portfolio? What are the programmatic implications for adding this method into the project?
4. During the past few years, IRH has significantly increased their technical assistance to the field for the SDM. Given the shift from research to technical assistance, is the AWARENESS project best placed in the RTU Division or would it be better placed in another division?
5. Is there a need for a follow-on project in RTU devoted to NFP?

V. METHODOLOGY

1. Self-assessment: USAID will request IRH to prepare a self-assessment of the Awareness Project, based largely on the questions above, and the report will be provided to the Evaluation Team as part of the background materials.

2. Preparation of Evaluation Workplan*:* An Evaluation Team of three consultants and is envisioned. The Team will initially meet with the USAID staff (RTU Division) to be briefed on the Georgetown IRH Agreement and the activities of AWARENESS. The key questions to be addressed in the Evaluation will be further refined and prioritized, and the general methodology to be used will be reviewed and discussed. The Team will then be responsible for developing the overall final Evaluation workplan, defining the responsibilities of individual Team members, developing interview questionaires, agreeing on a schedule for specific activities, and addressing other operational and logistical issues as needed.

3. Background Documents/Materials: The following documents will be provided to the Evaluation Team. Other documents may be added or requested as needed based on a complete list of documents to be prepared by the IRH.

   - PRH Results Framework
   - Last two management review reports
   - Cooperative Agreement HRN-A-00-97-00011
   - Last Evaluation Report (1994)
   - Annual Workplans, July 2002-June 2003 and July 2003-June 2004 (earlier years available upon request)
   - Annual Reports July 2003 to June 2004
   - Results Review documents for FY 2004
   - Self-assessment report from IRH
   - Significant research publications on SDM and TDM effectiveness studies and operations research
   - List of country programs
   - List of collaborating partners and CAs

4. Interviews: In consultation with the RTU Division, we anticipate that the Evaluation Team will extensively interview selected RTU and other USAID staff, including USAID Regional Bureau field staff, as well as staff from IRH at the headquarter and field levels. The team is also expected to interview other cooperating agencies, donors, Ministries of Health, researchers, advocates, or other parties chosen by the Evaluation Team.

   In most cases, it is expected that interviews with USAID or IRH staff will be conducted in person with the entire Evaluation Team present at the same time. Interviews with individuals who are not USAID or IRH staff will probably be conducted by telephone; again it is expected that the entire Evaluation Team conducts the interview as a group.

A list of suggested interviewees (informants) at IRH, USAID and other stakeholders will be provided.

5. Field Visits: The Evaluation Team will tentatively travel to India, Peru and Rwanda (1 consultant to each country) to visit ongoing AWARENESS subprojects. The Team will assess program implementation, research progress, stakeholder involvement, and potential for scale-up. The Team will also have the opportunity to conduct interviews with key informants to assess the extent to which NFP has been integrated into other programs. Site selection was determined by level of resources invested in research, size of programs, multiplicity of research studies implemented in country, support for the program by local Mission, and planned efforts for program scale-up.

VI. DELIVERABLES

1. Evaluation Report: The evaluation should organize and analyze data collected from interviews and field visits to be synthesized into a final report. The Evaluation report (about 30 pages, plus attachments) should describe the methodology, provide conclusions on the key evaluation questions and offer key recommendations for the future. This Report is primarily intended for internal USAID use in assessing the performance of the AWARENESS project and defining future program needs and, therefore, may or may not be widely distributed. All or parts of the report will be shared with IRH. However, recommendations to USAID regarding future procurement issues will be kept internal to USAID.

2. Debriefings: The Evaluation Team will provide separate debriefings to both USAID and IRH in Washington D.C.

VII. TEAM COMPOSITION

The Evaluation Team must be qualified to make a wide range of possible recommendations, and be sufficiently respected and influential so that their recommendations will be considered to be authoritative. We do not want a review that only confirms preconceived conclusions or views held by USAID staff or IRH.

It is expected that three consultants with complementary knowledge in this technical area will be sufficient for the Evaluation team. The consultants, as a Team, should have expertise in the following areas:

- Knowledge of and interest in natural family planning and related issues
- Experience in the management of family planning and other reproductive health services in developing countries
- Knowledge of operations and program research and service delivery issues related to reproductive health technologies in developing countries
- Knowledge of issues related to information dissemination and utilization of research for program improvement

- Developing country experience.

Potential candidates for this team may include: senior and possible retired persons with careers related to contraceptive research and development, and/or reproductive health care in developing countries. The candidates must be able to work as a team member, evaluate and synthesize information quickly, make clear and well-founded recommendations, and contribute to the written report and debriefings. Careful judgment should be used to recruit consultants who are knowledgeable and highly respected in this field, but are unbiased about this technical area and its future directions.

It is estimated that up to six weeks of effort will be required for each of the consultants on the Evaluation Team, and possibly an additional week for the team leader.

VIII. SCHEDULING AND LOGISTICS

Once the consultants for the Evaluation Team are identified and recruited, the process for document review and interviews with key informants can begin in order to conduct field visits in February-March, 2006. A timeline will be developed to ensure sufficient opportunity for report writing, including edits and revisions, as well as final debriefings. The Evaluation Team should adhere to the agreed to timeline.

It is anticipated that 2-3 trips to Washington, 1 trip each to Peru, India and Rwanda will be required to conduct the Evaluation and debriefings.

Appendix 3
The evaluation: methodology, questions addressed, timetable and key dates

Team Composition;
Cynthia Steele
Bob Blomberg
Emma Ottolenghi, team leader

Purpose of evaluation
The purpose of this evaluation was to assess the performance of the AWARENESS Project and provide information to USAID for the design of a possible follow-on project. Specifically, the evaluation team is expected to:

- Assess the performance of the Awareness Project relative to the goals and objectives of the cooperative agreement and the Office of PRH;
- Assess the impact of research findings, new methods developed, and capacity building activities on family planning and reproductive health programs worldwide;
- Provide guidance to USAID on the scope for a future project and mechanisms of funding.

Evaluation Methodology:

Briefings: the evaluation team was briefed by USAID RTU and Service Delivery divisions as well as by the IRH management staff.

Document Review: IRH provided a large selection of briefing and back-up documents for review including:

- PRH Results Framework
- Management review reports, 2004 and 2005
- Cooperative agreement HRN-A-00-97-00011
- Evaluation report, 2004
- Annual Workplans 2002-2003, 2003-2004, 2004-2005, 2005-2006
- Annual Reports 2003, 2004
- IRH Self-assessment report
- Selected significant publications from peer review journals and popular press
- List of country programs
- List of collaborating partners and CAs
- Selected country briefing summaries

Interviews: key informants included USAID/W and Mission present and past staff, IRH Washington based and field staff, persons from other research agencies, CA and PVO headquarters' and field based staff, many field persons in IPPF affiliates, private (NGO) and public (ministries of health and social security agencies) family planning service sectors working with the IRH as well as persons working in international agencies (WHO, UNFPA). Interviewees

were selected from extensive lists provided by IRH and the USAID RTU staff and based on their availability. The list of contacted persons is in Appendix 5.

Field Visits: at USAID and IRH request, the countries visited by team members were India, Rwanda and Peru. Site selection was determined by level of resources invested in research, size of programs, multiplicity of research studies implemented, support by the local Mission and planned efforts for program scale-up. See Appendix 6 a, b, and c: Visited Country Reports

The Evaluation Questions Provided by USAID are:

A. Research Results and Program Impact

1. Research Results
    a. To what extent has IRH successfully achieved the project results outlined in their Results Framework (Attachment 1)?
    b. What unexpected results, positive and negative, have been achieved that were not originally projected in the Cooperative Agreement?
    c. What gaps, if any, exist in their research agenda? Please outline any major questions that remain to be answered regarding the new NFP methods and their use in programs.

2. Program Impact
    a. What is the process that IRH follows to disseminate research findings and ensure utilization of information and new methods developed? How well is the process functioning?
    b. How effectively does IRH work with other research and service delivery CAs, Ministries of Health, and other FP and NFP organizations to implement studies and utilize research findings internationally and in developing countries? Please identify specific examples of collaboration.
    c. How effective has IRH been in moving NFP from "research to practice" To what degree has NFP been mainstreamed into FP/RH programs and services? Please identify specific examples of capacity built in international and developing country organizations to provide NFP and please provide an estimate of the numbers of users of the SDM and TDM worldwide.
    d. At the service delivery level, do any challenges exist for NFP utilization and scale-up? At the headquarters, national and mission levels, what challenges exist for NFP integration into FP programs? What steps have been and should be taken to address the above challenges?
    e. Although the SDM is a natural method and, therefore, not dependant on any contraceptive commodities, the method is closely associated with the Cycle Beads teaching tool. How dependent are clients and programs on the Cycle Beads? What are some of the challenges facing programs in procuring these beads or manufacturing them locally and what should be USAID's position regarding this tool and future expansion of the method?

B. Management and Financial Issues

1. Management
    a. How does the current management structure and administrative system enhance or inhibit the implementation of the cooperative agreement? Are project resources and activities being allocated to maximize efficiency and impact? In what ways, if any, should the structure and management processes be changed?
    b. How efficient is IRH in developing research projects? How efficient is the approval process for implementing new studies? Is the time from concept development to field

implementation reasonable? What, if any, process and management changes are needed to improve efficiency?

c. How successful has IRH been in recruiting and retaining staff well-suited to achieving the objectives of the cooperative agreement? Are there areas where additional staff is needed, or where a reduction in staff would be appropriate? How well does IRH use contract staff?

d. What are the strengths of the relationship between IRH and USAID (RTU, PRH, GH, Regional Bureaus and field Missions) and how can the relationship be improved? What are the strengths of the relationship between IRH and the project management team and how can the relationship be improved?

2. Funding issues

a. How does the funding allocation within IRH relate to the objectives of the cooperative agreement?

How appropriate are the decisions that have been made when budgets had to be reduced or increased?

b. To what degree have USAID funds been used as seed money to attract other funds including support from other donors? What type of changes should occur, if any, to facilitate this process?

c. Do trends in funding appropriately reflect project achievements? To what extent have funding trends had an impact on IRH management?

C. Future Directions

1. Are major changes needed to the overall objectives of the current program? If so, in which areas, and to what extent?
2. What are the future research initiatives that should receive priority attention, and what, if any, barriers to progress will need to be addressed within a new program?
3. What is the capacity of the project to incorporate LAM into their existing portfolio? What are the programmatic implications for adding this method into the project?
4. During the past few years, IRH has significantly increased their technical assistance to the field for the SDM. Given the shift from research to technical assistance, is the AWARENESS project best placed in the RTU Division or would it be better placed in another division?
5. Is there a need for a follow-on project in RTU devoted to NFP?

In addition to the USAID questions, the evaluation team developed the following questions; these were used selectively to guide interviews conducted with CA and NGO headquarter and field staff and other partners visited during country visits:

- Describe the nature of the work together.
- Describe the collaboration experience.
- What worked well? What could be improved upon in the future?
- What's the perception of IRH in CA community?
- What lessons have you learned that can applied in the future?
- Has IRH developed capacity of your organization to offer FAM (or other, e.g. Counseling)? How? Is any ongoing TA needed (and if so what?) or has FAM now been mainstreamed in your agency?
- What has been most and least useful about their capacity-building? Any lessons learned for the future?

- What are the challenges for NFP integration into FP—at service delivery level? At HQ/within the CA? Is provider bias (for or against NFP) a factor? How to overcome it? Is the cost of beads a factor?
- Are providers/managers in field aware of/using tool to estimate cycle bead needs? Are there sufficient supplies at all levels? What happens if USAID did not provide, i.e. would country or program purchase?

D. Evaluation Timetable

- Mid January: The evaluation team members received a large amount of briefing documents to be reviewed
- 2/5/06 Team traveled to Washington DC on 2/5.
- 2/6/06 USAID and IRH briefings
- 2/23-25 to 2/28-3/1 Field visits to India, Peru, Rwanda
- 3/15 USAID presentation
- 3/16 IRH presentation
- 3/31 Submit semifinal report to USAID, IRH, Links Media for suggested edits
- Date depending on when comments are received: Final report to Links Media for edits and formatting

See also, Appendix 2 for a complete file of the evaluation SOW

Appendix 4
Persons Interviewed

USAID/Washington

Michal Avni, Coordinator for Gender Working Group, PRH/Policy Evaluation and Communication Division
Gloria Coe, CTO, JHU/CCP
Shanti Conly, HIV/AIDS Division and Team Leader for Youth
Jewel Gausman, Project Assistant
Sarah Harbison, Deputy Chief, Research, Technology and Utilization (RTU)
Mihira Karra, AWARENESS Project Technical Advisor
Virginia Lamprecht, PVO Advisor
Ann Lion, RH Advisor, PRH/Service Delivery Improvement (SDI)
Shawn Malarcher, TA, FRONTIERS, Pop Council
Maureen Norbert, Senior Technical Advisor and CTO for Expanding Service Delivery Project, PRH/SDI
Rushna Ravji, Technical Advisor for MAQ, PRH/SDI
Mark Rilling, Division Chief, PRH/Commodities Security and Logistics
Margaret Neuse, Director, Office of Population and Reproductive Health (retiring)
Scott Radloff, Director (incoming), Office of PRH
Jim Shelton, Medical Officer, PRH
Jeff Spieler, Division Chief, PRH and CTO, AWARENESS project
Patricia Stevenson, CTO, FRONTIERS Project
Dana Vogel, Division Chief, PRH/SDI
Elizabeth Warnick, Research Utilization Advisor, PRH/RTU

Georgetown University Institute for Reproductive Health

Washington Staff
Victoria Jennings, Ph.D., Director
Marcos Arevalo, MD, Director of Biomedical Research
Rebecka Lundgren, Director of Operations and Behavioral Research
Caroline Blair, Director of Programs
Jeannette Cachan, Director of Training and IEC
Irit Sinai, Ph.D., Senior Research Officer
Daren Trudeau, Program Officer
Jerry Marcus, Program Officer
Claudia Velazquez, Program Officer
Monica Marini, Program Officer
Bernard Balibuno, Program Officer
Aysa Saleh-Ramirez, Program Officer
Myrna Seidman, Consultant

Field Staff
(see below for IRH staff interviewed in Peru and Rwanda)
Margarita Monroy, El Salvador
Diony Fuentes, Nicaragua

Claudia de la Quintana, Bolivia
Gretzel Jove, Bolivia
Arsene Benanga, DRC
Gilbert Belade, DRC
Candide Dahoun-Agbobatinkpo, Benin

USAID/Missions
(see below for USAID staff interviewed in India, Peru, Rwanda)
Benin
Pascale Zinzindohoué, Family Health Team Leader
Bolivia
Rocio Lara, Project Monitor
Democratic Republic of Congo (DRC)
Ellen Lynch, Director of Health Program
Aleathea Musa
Honduras
Dr. Maria del Carmen Miranda, previous Health Advisor
Nicaragua
Claudia Evans, SDM Monitor

WHO
Catherine D'Arcangues, FP/RH Division

US Based Cooperating Agency Staff
Lynn Bakamjian, Project Director, Acquire, Engenderhealth
Jean Baker, Project Director, Linkages
Maxine Eber, Technical Adviser, Africa, Population Services International (PSI)
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Tarapoto
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Karen Blyth, Director, CAPACITY Project, Intrahealth
Laura Hoemeke, Director Twubakane, Intrahealth
Defa Wane, FP/RH Advisor, Twubakane, Intrahealth
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Staci Leushchner, Country Director, PSI
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J. Bosco Mugemanshuro, Supervisor, Byumba Hosp.
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Sœur Yvette Vincent, Director of Bungwe Health Center
Cécile Mujawayezu, Provider, Bungwe Health Center
Léontine Murakatete, Provider, Bungwe, Health Center

South Province
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Marcianne Mukankubana, Community Spokesperson
Pierre Claver Bazumutima, Community Leader, Representative
Drocella Mujawamariya, President, Health Committee

Appendix 5
IRH-2: Studies conducted and key findings

Study Type and Title	Primary Research Questions	Study Sites/Countries	Dates	Country/Research Orgs./Service Delivery Orgs.	Key Study Findings
Pilot, efficacy and long term follow-up studies					
A Fixed Formula to Identify the Fertile Window of the Menstrual Cycle	Days When pregnancy is likely in regularly-cycling women	WHO data from 5-country study; charts from 3 NFP programs	1999		For women with cycles 26-32 days long, pregnancy is likely only on days 8-19.
Efficacy Study of the SDM	Feasibility, acceptability and efficacy of the method	Total of five sites in Philippines, Peru and Bolivia	01/00-08/01	Philippines: IRH Phil., MOH Peru: IIN, CARE, ISR Peru, MOH Bolivia: CARE, CRS, CIES (IPPF), MOH, CARITAS	For women with cycles that usually range 26-32 days long, pregnancy is likely only from intercourse on days 8-19.
Long-Term Follow-Up Study of Users from SDM Efficacy Trial	Continuation, use of method to prevent and achieve pregnancy, use of other methods	Philippines, Peru, Bolivia studies	2001-2003	Philippines: IRH Phil., MOH Peru: IIN, CARE, ISR Peru, MOH Bolivia: CRS, CIES (IPPF), MOH, CARITAS	The method continues to be effective with long-term use. Users who complete the first year without a second cycle out of range are likely to continue using the method long-term.
Long-Term Follow-Up of Users Completing SDM OR Studies	Continuation, use of method to prevent and achieve pregnancy, use of other methods	Ecuador, Honduras, India and Benin	In progress May 2003-	Ecuador: CEMOPLAF, CEMOPLAF Honduras: ASHONPLAFA, ASHONPLAFA, MOH India: TNS MODE CEDPA, CARE, CASP Benin: OSV-Jordan, OSV-Jordan, HOMEL, ABPF (IPPF)	Method continues to be highly effective. Women who survive the first year without a 2nd cycle out of range are likely to continue using the method long term.
A Secretions-Based Algorithm to Identify the Fertile Time in the Menstrual Cycle	Considering presence/absence of secretions, which days should be considered fertile	WHO data from 5-country study, charts from 3 NFP programs	1999		Presence of secretions "today" or "yesterday" indicates probable fertility.

Study Type and Title	Primary Research Questions	Study Sites/Countries	Dates	Country/Research Orgs./Service Delivery Orgs.			Key Study Findings
Efficacy Study of the TDM	Feasibility, acceptability and efficacy of the method	Five sites in Guatemala, Peru, Philippines	02/02-06/03	Guatemala	APROVIME	CDRO	The TDM is more than 96% effective with correct use. Couples can use the method correctly in 96% of cycles.
				Peru	ISR Peru, CARE, INPPARES (IPPF)	MOH	
				Philippines	IRH Phil.	MOH	
Long term Follow-Up Study of Users from the TDM Efficacy Trial	Use and continuation of TDM, use of other family planning methods after discontinuation	Three sites in Peru and Guatemala	03/03-08/05	Guatemala	APROVIME	CDRO	The method continues to be highly effective with long-term use. Two-thirds of women who entered the study at the end of the efficacy study were still using the method 2 years later.
				Peru	ISR Peru, INPPARES	MOH	
Postpartum Guidelines Study	Feasibility and acceptability of fertility awareness-based guidelines for postpartum women	Guatemala and Peru	08/04-08/05	Guatemala	APROVIME	APROVIME, CDRO	Guidelines are acceptable and easy to learn/use. Preliminary efficacy is good, but sample size is too small for precise calculations.
				Peru	ISR Peru	MOH	
Operations Research and Case Studies							
Case Study on SDM Introduction	Document introduction strategies in three organizations	Benin	12/01-09/03	Benin	LEADD	HOMEL (national maternity hospital), ABPF (IPPF) OSV-Jordan	Most couples using the method expressed satisfaction with it, and about 25% said it improved the couple's relationship. Most would also recommend the method to others. Absence of side effects was the most frequently cited reason for using the SDM. 70 % of SDM users were first-time family planning users or had not used an effective method prior to SDM use.

Study Type and Title	Primary Research Questions	Study Sites/Countries	Dates	Country/Research Orgs./Service Delivery Orgs.	Key Study Findings
					SDM was 30% of the method mix in the OSV-Jordan program in Benin Serving mostly rural areas.
Test Counseling Protocols for SDM Introduction	Differences in use and satisfaction based on receiving either one or two counseling sessions.	Ecuador	07/01-01/03	Ecuador / CEMOPLAF / CEMOPLAF	A comprehensive reproductive health program can include the SDM; it is feasible to offer the SDM at the community level as well as in clinics; it can be used by women of all socio-economic groups; no significant advantage to offering the SDM through a two-visit counseling approach. Users were willing to pay more than price set during study. Provider attitudes improved over time.
SDM Introduction into Community-Based Water and Sanitation Programs in Rural Areas	Male participation in family planning and the feasibility of introducing SDM into a non-health organization	El Salvador	06/01-01/03	El Salvador / ASHONPLAFA / Project Concern International, CIRES	SDM had an impact on contraceptive prevalence in study communities; 60% of SDM users had never previously used a family planning method; involving men in family planning contributed to higher contraceptive prevalence and a greater use of couple- and male-based methods.

Study Type and Title	Primary Research Questions	Study Sites/Countries	Dates	Country/Research Orgs./Service Delivery Orgs.			Key Study Findings
SDM Introduction into Three Organizations	Acceptability of SDM in urban and rural communities	Honduras	06/01-01/03	Honduras	ASHONPLAFA	ASHONPLAFA CEVIFA/CRS Honduran MOH	Provider bias against natural methods declined significantly over the two-year study period contributing to improvements in informed choice; 20% of SDM acceptors were first time family planning users. It was feasible to offer the SDM in both rural and urban settings, and it could be offered by community promoters and clinic-based providers. There were differences in SDM acceptance and use among the three institutions. Public and private sector clinics had more users, but the FBO had fewer discontinuations.
SDM Introduction in Community-Based Programs in Low Resource Settings (urban slum in New Delhi)	Testing of mnemonic devices to help users track their cycles	India (New Delhi)	04/01-09/03	India (New Delhi)	TNS MODE, CEDPA, PSI	CASP Plan	There was demand for the SDM, and providers and clients found SDM simple to teach and use. Most users were very satisfied with the method and were able to use it correctly. Contraceptive prevalence increased from 50 to 58% after introduction of the SDM, and 70% of the new users had been using condoms inconsistently before adopting the SDM. CycleBeads are an

Study Type and Title	Primary Research Questions	Study Sites/Countries	Dates	Country/Research Orgs./Service Delivery Orgs.			Key Study Findings
							effective, appropriate tool for learning and using the SDM.
SDM Introduction in Rural Villages	Use of male volunteers compared to women volunteers	India (Uttar Pradesh)	05/01-08/03	India (Uttar Pradesh)	TNS MODE	CARE	Results show that the SDM can be provided and used successfully by couples with little or no education. About half of the women who adopted the SDM were first-time family planning users. Training male community health workers was a successful strategy for reaching men; 81% of women in villages with male volunteers reported that their husbands were counseled on method use, in comparison to 2% in villages with only female volunteers.
Incorporation of SDM in Public Health Services	Feasibility of integrating the method into regular service settings on a large scale	Peru	07/02-08/05	Peru	ISR Peru	MOH, ADRA, Ministry of Social Dev., PRODEMU, PROSALMAG, CARITAS, police	The method is feasible to introduce on a large scale into public programs. Efficacy was high in regular service delivery. Most users were not using any method before adopting SDM. Condom users continued using condoms during the fertile time.
SDM Introduction into Family Planning Services in a Large Maternity Hospital	Comparison of two counseling protocols: one counseling session versus two	Philippines, (Manila)	10/01-03/03	Philippines (Manila)	Arts & Science Interdisciplinary Network	Fabella Maternity Hospital	Follow-up or second visit did not significantly improve correct use of the SDM. One visit sufficient.

Study Type and Title	Primary Research Questions	Study Sites/Countries	Dates	Country/Research Orgs./Service Delivery Orgs.			Key Study Findings
SDM Introduction in an Agricultural Cooperative	Feasibility of introducing SDM into organization and comparing use of males and couple educators	Philippines (KAANIB)	10/01-03/03	Philippines (KAANIB)	Research Institute for Mindanao Culture (RIMCU)	KAANIB People's Organization	Non-health workers can offer the SDM, but retaining volunteers is problematic. Training and management is more resource-intensive than is training health providers.
Introduction of SDM into a Fee- for-Service Multi-Method Family Planning Organization	Willingness of clients to pay for CycleBeads and the SDM	Philippines (Friendly Care)	05/02-03/03	Philippines (Friendly Care)	Asian Institute of Journalism and Communication	Friendly Care	Clients are willing to pay for CycleBeads and the SDM, but investments in method promotion are crucial.
Mid-Term Assessment of the Standard Days Method (SDM) Introduction in Rwanda	Assess providers' ability to correctly offer the SDM. Describe client satisfaction, correct use of SDM and interest in continued use.	Rwanda – 13 pilot sites country wide	08/03/- 09/03	Rwanda	Felix Muramatsa	MoH, NGOs, FBOs	Providers can offer SDM correctly. SDM is an appropriate addition to the method mix. Significant demand exists and clients are able to use correctly. Most SDM clients are first time FP users
Assessment of the Standard Days Method (SDM) Introduction in the Democratic Republic of Congo (DRC)	-Assess providers' ability to correctly offer the SDM. -Describe client satisfaction, correct use of SDM and interest in continued use.	Kinshasa, DRC- 58 clinics	11/05-FY06	DRC (Kinshasa)	BEM-SPRL	MoH, NGOs, FBOs	Simulated clients found that providers understand the SDM and can correctly offer the method to clients. FGD and KII planned for FY06.
Special Studies							
Test WHO Decision-Making Tool Used in Family Planning Counseling	Utility of the decision-making tool for counseling	Nicaragua	09/04-05/05	Nicaragua	FHI, JHU/CCP	MOH	Decision-making tool is well regarded and contributes to improved counseling.
Comparative Effectiveness of SDM	Correct use and continuation of SDM	Guatemala	In progre	Guatemala	APROVIME	MOH	

Study Type and Title	Primary Research Questions	Study Sites/Countries	Dates	Country/Research Orgs./Service Delivery Orgs.	Key Study Findings
User Tools	using CycleBeads and a printed image		ss 10/05-		
Testing Counseling Protocols for the TDM	Assess whether correct method use, continuation and satisfaction are affected by timing of instruction during the menstrual cycle; assess feasibility of introducing the TDM into regular service delivery systems.	Nicaragua and Peru	In progress 09/05-	Nicaragua: IRH; MOH Peru: ISR/Peru; MOH	
Effectiveness of KIT in Improving Provider Competence in SDM Services	Compare effectiveness of KIT and traditional group refresher training in improving provider competence.	Guatemala	In progress 08/05-02/07	Guatemala: APROVIME; MOH	
Social marketing studies					
Three studies using the same protocol to test the effectiveness of social marketing efforts in increasing access to the SDM.	Measure the impact of SDM social marketing activities; measure quantity of SDM information provided by clinics and pharmacies; measure correct use and satisfaction by clinic and pharmacy users. (baseline/endline community KAP; simulated clients; client follow-up)	Ecuador Benin DR Congo	In progress 01/05-	Ecuador: CEMOPLAF; CEMOPLAF Ecuadorian MOH Benin: Centre de Recherche en DR Congo: BEM; PSI	Baseline surveys indicate that there is a greater interest in using the SDM in Africa than Ecuador; in all countries, clients would be willing to pay for SDM and are favorable to sales through pharmacies. Ecuador baseline/endline surveys showed that the social marketing efforts did have an impact on increasing potential demand and knowledge but not on

Study Type and Title	Primary Research Questions	Study Sites/Countries	Dates	Country/Research Orgs./Service Delivery Orgs.	Key Study Findings
				DR Congo | BEM | PSI	total sales. Clinic-based providers provided better quality information to clients than pharmacists. Ongoing follow-up study will provide information on correct use by clients who purchase at pharmacies.

<table>
<tr><td colspan="5">Impact Studies</td></tr>
<tr>
<td>Test the effects of scaling-up interventions to include the SDM in service delivery systems and make communities aware of it as a family planning option</td>
<td>1)The extent to which providers offer the SDM in a non-biased manner, 2) the effects of SDM introduction on new family planning users and method mix, and 3) effect on contraceptive prevalence, knowledge and attitudes. (baseline/endline community KAP; simulated clients; client follow-up)</td>
<td>India
Peru
Rwanda</td>
<td>In progress
10/04-
<table>
<tr><td>India</td><td>TNS MODE</td><td>MOH/ Family Welfare KGVK, CARE, HLL</td></tr>
<tr><td>Peru</td><td>ISR Peru</td><td>MOH, Adventist churches, NGOs, FBOs, Social Security, police</td></tr>
<tr><td>Rwanda</td><td>Smart Consultancies, MOH (Central)</td><td>MOH Byumba and Kibungo/Kihere Provinces</td></tr>
</table></td>
<td>Preliminary results from Peru and Rwanda show that some providers erect unnecessary medical barriers to SDM use. Results from India, Rwanda, and Peru show that provider’s score better offering the SDM than other methods, but quality scores for all methods are low in India, and could still be improved in Rwanda and Peru.</td>
</tr>
<tr>
<td>Evaluation of an SDM Behavior Change Communication (BCC) Campaign</td>
<td>Determine the impact of the campaign on awareness of SDM and providers’ attitudes through household surveys, client interviews, and provider interviews.</td>
<td>Bolivia</td>
<td>In progress
03/05-05/06
<table>
<tr><td>Bolivia</td><td>Promotores en Comunicacion</td><td>MOH</td></tr>
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Appendix 6
CycleBeads History and Development

When the concept of using a necklace with different beads to identify different phases of the menstrual cycle was first being explored, IRH worked with several overseas partners to test the feasibility of having the necklaces made locally (i.e., Ecuador, Philippines). After about six months, it became apparent to both IRH and the participating partners that this was not going to work, that manufacturing the necklaces was not the business that any of the agencies had the competency to be in. IRH then developed specifications for the necklace and posted them on a website for individuals/companies seeking the manufacture of products. Manufacturers access these specifications and make proposals for making products that are within their business interest. IRH received a number of proposals, with prices ranging from just under $2 per unit, to just over $8 for their manufacture. The lowest price offer came from China where it was not legal to spend USAID population money. At that point, Victoria Jennings had a conversation with her daughter who is a partner in a business, Cycle Technologies, which has experience arranging for the manufacture of bicycle parts to specification. Her daughter's firm, which has experience in marketing and global distribution, was willing to take the initiative in negotiating manufacture of the necklaces, under license from Georgetown University, which holds the patent, recognizing that their time would be donated to the effort. They also agreed to handle distribution.

Before moving forward with a contract, Jennings brought the proposed arrangement to the Georgetown University ethics office to seek advice and concurrence on the acceptability of the business relationship that involved a family member. The ethics office found nothing unethical about the proposed relationship, and Jennings completed the appropriate disclosure documents as required by the University. Jennings and a representative of the ethics office then met jointly with USAID to discuss the proposed arrangements and seek clearance to move forward. The USAID legal office found the proposed relationship was acceptable because it was understood and agreed that no royalties would be paid to any party for the sale of the beads to international programs: not IRH, not Cycle Technologies, not Georgetown University. Further clearance was obtained for the proposed arrangement from the Assistant Administrator of USAID. It should be noted that Cycle Technologies was permitted to earn royalties on domestic sales of CycleBeads; these royalties are paid to IRH and to date amount to about $7,000.

Cycle Technologies has contributed hundreds of hours of professional time as well as uncompensated technical and legal expertise to make the manufacture of CycleBeads possible at the current price. Additionally, they have procured product liability insurance and volunteered expert time to PATH in preparation of the CycleBeads Production and Procurement Guide. Cycle Technologies pays royalties to Georgetown University on domestic sales of CycleBeads: to date these amount to slightly less than $7,000. Distribution of CycleBeads to USAID and its partners is handled at cost.

Appendix 7
Tables of SDM Providers

Table 1. Number of SDM providers, sites, users, and CycleBeads distributed, in selected countries/sites

	Benin	Bolivia	DRC	Ecuador	Honduras	India	Madagascar	Peru	Rwanda	Tanzania	Total
Providers											
Clinic	214	1,414	506	431	793	296	49	1,448	253	39	5,443
Community	24	-	644	-	57	999	2	-	-	9	1,735
Promoters[1]	31	241	860	122	55	1,820	-	660	2,221	4	5,148
Sites											
Clinic	127	376	431	56	741	84	27	566	48	22	2,748
Community	7	1	4	-	-	121	4	-	2	-	139
Number Users	2,500	11,978	3,800	2,100	1,700	2,000	319	4,300	3,500	1,000	33,197
Number of CycleBeads	5,000	15,000	24,000	10,500	10,000	30,000	1,000	20,000	N/A	3,000	118,500
Percent of first time user[2]	70%	N/A	93%	20%	53%	56% (rural) 32% (urban)	61%	94%	96%	70%	
Percent of new SDM users in method mix	7%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	6%	N/A	

Source: Population data for all countries: International US Census Bureau website links to country national statistics websites at http://www.census.gov/main/www/stat_int.html. Benin population data from: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, *World Population Prospects: The 2002 Revision* and *World Urbanization Prospects: The 2003 Revision*, http://esa.un.org/unup, 22 March 2006.
All other information provided in this table come from country and project quarterly service reports from 2001 to 2005.

[1] Promoters are health personal trained inform, promote, and refer clients. They do not provide the method.
[2] First-time SDM user = never used method, used an ineffective method (rhythm, withdrawal or periodic abstinence), used condoms inconsistently.

Table 2. Characteristics of a SDM user in selected countries

	Mean age	*Parity*	*Education level*	*First-time SDM user*[1]
Benin (N=219)	29	2.2	High School	70%
Ecuador (N=165)	30	2.0	High School	30%
Honduras (N=109)	29	1.9	High School	33%
India-Rural (N=485)	29	3.8	NA	67%
India-Urban (N=284)	29	2.8	NA	28%
Peru (N=5000)	29	2.1	NA	94%

Source: OR Study Final Reports for Benin, Ecuador, India, and Honduras; Peru MOH Service Statistics.

[1] First-time SDM user = never used method, used an ineffective method (rhythm, withdrawal or periodic abstinence), used condoms inconsistently.

Appendix 8
IRH Publications

Articles in Peer Reviewed Publications

Sinai I, Jennings V, Arevalo M. The TwoDay algorithm: a new algorithm to identify the fertile time of the menstrual cycle. *Contraception* 1999; 60(2):65-70.

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Articles in Professional Publications

Jennings V. Family planning with natural methods: an important option for patients. *The Integrative Medicine Consult,* November 1999; 1(16):152-153.

Arevalo M, Jennings V. Simple methods of natural family planning. *IPPF Medical Bulletin* 2000; 34(3).

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Articles Submitted for Publication

TITLE	AUTHOR	JOURNAL
New Approaches to Fertility Awareness-Based Methods: Incorporating the Standard Days Method into Family Planning Services in Africa	El Haj Ousseynou Faye, MD Caroline Blair, MBA Philippe Moreira, MD	Society for African Gynecologists and Obstetricians (SAGO)
Providers' Information Exchange with Clients in India, Peru, and Rwanda	Federico R. León, MA, Ph.D. Rebecka Lundgren,MPH Ana Huapaya, BA	Studies in Family Planning (submitted)
Planificando Juntos para el bienestar de la familia	Rebecka Lundgren,MPH Margarita Monroy, RN	Pan American Health Organization (PAHO) (submitted)
Challenging the Courtesy Bias Interpretation of Client's Favorable Perceptions of Family Planning Delivery	Federico R. León, MA, Ph.D. Rebecka Lundgren, MPH Ana Huapaya, BA Victoria Jennings, Ph.D. Irit Sinai, Ph.D.	Journal Evaluation Review

TITLE	AUTHOR	JOURNAL
New Approaches to Fertility Awareness-Based Methods: Incorporating the Standard Days and TwoDay Methods into Midwifery Practice	Elaine Germano, CNM, DrPH, FACNM Victoria Jennings, Ph.D.	Journal of Midwifery & Women's Health (JMWH)
A New Look at Fertility Awareness-Based Methods of Family Planning: Non-Hormonal Options for Your Patients	Victoria H. Jennings, Ph.D. Helain J. Landy, M.D.	Contemporary OB-GYN
New Approaches to Fertility Awareness-Based Methods: Implications of Offering the Standard Days Method in Ethiopia	Befekadu Demmissie, MPH, BSc. Caroline Blair, MBA	Ethiopian Journal of Health Development
Quality of Delivery of Standard Days Method vis-à-vis Pills in Rwanda	Federico R. León, MA, Ph.D. Caroline Blair, MBA Victoria Jennings, Ph.D. Ana Huapaya, BA Marie Mukabatsinda, PHO Félix Muramutsa, Lic Rebecka Lundgren, MPH	Journal of Family Planning and Reproductive Health Care (submitted)
Quality of Care Effects of Introducing the Standard Days Method (SDM) at Peru Ministry of Health Clinics	Federico R. León, MA, Ph.D. Marcos Arévalo, MD, MPH Ana Huapaya, BA Victoria Jennings, Ph.D. Luisa Sacieta, MD Rosario Panfichi, Ph.D.	Studies in Family Planning (submitted)
Introducing the Standard Days Method: Expanding Family Planning Choice in Africa	Caroline Blair, MBA Irit Sinai, Ph.D. Marie Mukabatsinda, PHO Felix Muramutsa, Lic.	African Journal of Reproductive Health
Being Strategic about Contraceptive Introduction: the Experience of the SDM	Rebecka Lundgren, MPH Jay Gribble, ScD Claudia Velasquez, MPH Erin Anastasi, MPH	TBD

Appendix 9 (a)
India country visit summary: Emma Ottolenghi

Country visit dates: 2/2506-3/2/06
Activities: accompanied by Ms. Priya Jha, CEDPA/IRH representative, meetings with a range of persons knowledgeable about IRH's work including USAID, CARE, Plan International, The Futures Group, MODE, Pathfinder (see Appendix # 4 for complete list); also, visit to CASP slum clinic. In Jharkhand, the main site for IRH's present activities in India, meetings with State officials, CARE and KGVK reps, visits to several villages and a small hospital where SDM is offered, and discussions (interpreted) with SDM users and providers.

Background on Family Planning in India [1]
India: 1+ billion population, 70% rural and 30% urban.

- CPR is 48%: made up of female sterilization 34%, condoms 3%; IUD and OCs 2% each,
- Traditional methods represent 5% of CPR (virtually no users identify fertile days correctly).
- High discontinuation rate of all methods
- Negligible FP use among young couples (women feel the need to prove their fertility)
- 78% of pregnancies are unplanned and 25% of them are unwanted (most terminate in abortion)
- 70% of women wishing to space next pregnancy are not using a method; non-use is related to health concerns and fears of sterilization.

The GOI National Population Policy (MCH II) will begin in 2007 with a goal, for the first time of pregnancy spacing. New methods to be included in MCH II are: SDM, injectables, LAM, EC and Centchroman (oral, non-hormonal contraceptive developed and used in India).

IRH in India
IRH has worked in India since 2001 in partnership with CEDPA and its NGO partners[2] IRH has worked in selected sites in 9 of 28 states, 2 of which are USAID priority states: Uttar Pradesh and Jharkhand. Jharkhand has 30,000 villages and a population of 27 million with a strong tribal component. This newly established state is a GOI priority.
The population reached with all the IRH studies is minimal compared with the total populations of the states where they were conducted. IRH provided technical assistance and funding to CEDPA and its partners[*]' for studies in urban slums and rural villages. IRH seconded one CEDPA staff in Delhi and 3 KGVK staff in Jharkhand. USAID/Delhi funding for private sector support was recently transferred from CEDPA to The Futures Group.

CB are manufactured by the Indian firm Ross Enterprises, subcontracted by Cycle Technologies. All interviewed persons stated that CB are essential for quality SDM services; all have worked up to now with IRH donated CB but most have been charging something for them; the exception is the Jharkhand scale-up project where CB are provided free of charge. The PLAN representative stated that it has, with IRH assistance, developed capacity to continue expanding SDM services and has private funds (from sponsorships) to purchase CB, which they will sell at affordable price.

[1] 98-99 NFHS II

[2] CARE, 3 NGOs associated with PLAN, World Vision, Pathfinder

SDM studies:
An operations research study on the feasibility/acceptability was carried out from 2002-4, with support from CEDPA. CARE, with research organization MODE, introduced SDM in 54 rural villages in U.P and tested benefits of involving men in FP. CASP, with Plan International, introduced SDM into FP by CHWs in Delhi slums.

SDM users are still being followed and 3 year continuation rates will be available in November, 2006. At 2 years, 67% women were still using SDM; the primary reason for discontinuation was desire to become pregnant; 4% discontinued because they or their partner did not like the method. Highlights of the results of the OR studies show that there is considerable SDM demand, particularly among younger couples not wishing to use other methods, that SDM can be provided to women/couples of varying educational and socio-economic levels by low literate and illiterate community workers, that new users used the method correctly and had high levels of satisfaction and 2/3 of users had not used other methods.

Ongoing research includes information needs of decision-makers and a long-term follow-up study of SDM users in Delhi and Sitapur, U.P. A scale-up and impact study of SDM introduction into public and private sectors in Jharkhand State, is being implemented by the NGO KGVK and the GOJ, with technical assistance from the Population Council and MODE. It aims to test SDM effects on client and community behaviors, perceptions and attitudes and the marginal cost of adding of SDM into service delivery settings, and includes a control group. The service component is via 94 auxiliary nurse midwives and 11 MDs in government facilities and recently expanded to Angarwadi workers (village-based community nutrition workers) and medical practitioners trained by CARE. Various informational formats (wall paintings, street theatre and village meetings) are being used to raise awareness of the method.

Another study of particular interest is with the NGO URMUL working with isolated desert communities in Rajasthan to test a satellite-based training program, including SDM for community workers. Finally, the development FBO PREM has just initiated SDM services (its only health related activity).

Approximately 2000 SDM users have participated in all completed and ongoing research studies (435 in the Jharkhand study).

Recommendations for future broad scale-up in India
Jharkhand today, and U.P. in 2007, offer a unique opportunity for broad SDM scale up, due to an impending change in service delivery providers who could bring greatly increased community outreach potential. The GOI is establishing a new cadre of community workers, Ashas (reproductive aged married women living in and elected by the community; no literacy requirements). They will be responsible for immunization, pregnancy care, FP, and malaria control and will be supervised by ANMs. The governmental Jharkhand Health Society (JHS), in association with 7 large NGOs will train 40-50,000 Ashas starting in 2006 and is now developing training materials; the FP module includes SDM, LAM and DMPA and EC. In addition, there are 13,500 Angarwadi nutrition workers who expanded their SOW in 2001 to include birth-spacing and HIV-AIDS. This large contingent of community-based workers will offer FP services to a majority of Jharkhand's population.

Factors facilitating broad scale-up are: 1) interest of the GOJ in addressing RH needs of its population; 2) very low CPR (14%); 3) existing strong private/public partnerships; 4) a provider pool who are trained in SDM from the start, rather than as an add-on, and 5) the JHS has sufficient funds to undertake the Asha training and supervision. In addition to challenges to scaling up related to the sheer size of the plan and those commonly encountered when working with governmental agencies, there are the following 1) NGOs are hesitant to work with the Government; 2) MDs/ANMs present barriers in operationalization because of territoriality and mistrust of lower level workers' abilities; 3) more effective communication strategies need to be tailored to the population; 4) SDM needs to be added into the MIS; 5) JHS cannot charge for CB; they may have to be sold privately or social marketed, so price may be a barrier.

The Futures Group (TFG) plans to apply lessons learned in Jharkhand, to assist approximately 40 NGOs in U.P. to train Ashas in 2007 with a coverage of approximately 1,500,000 population. The FP component includes SDM, LAM, injectables and EC.

The staff previously seconded to CEDPA will now be employed directly by IRH and TFG is making office space available for them in Delhi and U.P. Further, TFG requested that its own staff receive SDM training from IRH staff and is in conversation with the Catholic Bishop Conference in India, which has 4,500 partners and has requested an article on SDM for their official publication.

In summary, the coexisting circumstances described above offer an excellent though challenging opportunity to provide comprehensive FP services including SDM to a very large population. If successful, the GOI intends, through the MCH II program to expand FP and specifically birth spacing methods including SDM, via Ashas to enormous rural populations.

Appendix 9 (b)
Peru country visit summary: Bob Blomberg

Country visit dates: 2/25/06-3/4/06
Activities: Lima: meetings with USAID, IRH/Peru, MOH, Peruvian Federation of Midwives, Peruvian Association of Midwifery Schools, INPPARES (Peruvian IPPF affiliate), REDPLAN midwives, and research consultants. In Tarapoto, San Martin Department: meetings with regional health officials, local health center providers, and several long-term SDM users.

Peru: FP related data
27.5+ million population, (71% urban and 29% rural); ~7 million women of reproductive age.
Data from 2004 DHS:

- CPR 47% (modern methods): injectables 11.2%, female sterilization 10.4%, condoms 8.6%, pills and IUDs 7% each. 22% of couples use traditional methods with periodic abstinence being the most common (17.5%).
- Women in union 15-19 are less likely to use any method than older women
- There is only an 8.8% unmet need for family planning, considering current use of both modern and traditional methods.

IRH in Peru:
IRH has been active in Peru since 1998. The IRH strategy has focused on the MOH as the main partner for service delivery activities, especially in rural areas. Starting service delivery activities in one pilot area, they then moved to scale up in other areas. After launching their work with the MOH, they have moved to private sector organizations and urban areas. A key feature of their strategy has been work with universities that provide pre-service training for healthcare providers, which is seen as a key to long-term sustainability and as a way to establish credibility for modern FAMs in the healthcare community. In addition to working with the MOH, IRH works with EsSalud (social security system), INPPARES (IPPF affiliate); local offices of ADRA, CARE, FBOs, the National Association of Midwives (COP), the National Federation of Schools of Midwifery (ASPEFOBST), universities and others. Since 2000, all of IRH's in-country activities have been carried out by ISR/Peru (Instituto de Salud Reproductiva/Peru), a Peruvian NGO affiliated with IRH, although ISR continues to be funded in its entirety by the AWARENESS project.

Studies and activities:
Every major IRH study has included a study site in Peru: SDM/ TDM pilots, efficacy trials and long-term follow-up studies; an SDM Introduction Study; the SDM Impact Study; and the Study of Fertility Awareness-Based Guidelines for Postpartum Women.

As the results of the SDM efficacy trials became available in 2002, IRH shared them with the MOH; the Ministry expressed interest in introducing SDM into their FP services. The introduction process started with the selection of two provinces in a single Department (geopolitical area), San Martin, with possible expansion of services to other Departments contingent on the outcome of that experience.

In 2002-2003, IRH launched the gamut of needed activities for introduction of SDM in San Martin: training of MOH trainers in the Department, support of MOH trainers for training of providers,

collaboration on the development of IEC materials, supervisory visits to providers, integration of codes for SDM in the MIS, and the logistics of CycleBeads availability. The SDM became available in 63 sites in two provinces in September 2002.

In 2004, MOH directors from neighboring provinces within San Martin Department requested TA and support to incorporate SDM in their service networks. At the central level, the MOH authorities added the SDM to the National Guidelines of Reproductive Health and National Norms of Family Planning and asked IRH for TA and support to scale up the SDM nationwide. Limited resources prevented IRH from responding to the request. MOH interest in SDM triggered similar interest from the social security system, the IPPF affiliate, universities, as well as Pathfinder, the lead CA in Peru.

San Martin continues to be the locus of IRH's SDM scale-up initiative in Peru, although the pilot was officially completed in 2005 and ISR is no longer providing TA there. As of 2006, there are over 340 MOH facilities throughout all provinces of San Martin where SDM is available. SDM is also available from a small number of NGOs, FBOs, and others. Approximately 6% of all new MOH family planning clients in San Martin are SDM users. Appendix #10 shows the growth in volume of SDM users in the Department since the method first became available there in September, 2002. It is worth noting that less than 5% of new SDM users have switched from an effective FP method, according to findings from a follow-up study of SDM clients. IRH research has also found that condom use continues among those who previously used condoms, but the scheduling of their use is informed by the SDM fertile days, thus increasing use-effectiveness.

More recently, IRH has extended SDM service start-up to urban and peri-urban areas of Health Region III in Lima Department, again working with the MOH, but also through INPPARES' network of private midwives (REDPLAN) who serve low income communities throughout the region. Its proximity to Lima, combined with the fact of its huge population – over 1 million women of reproductive age – and the availability of health care providers made Health Region III a good target for studying user acceptance of SDM in an area where other FP modern methods are more readily available.

The strategy the IRH used to launch its work in Peru – focusing on the MOH as the linchpin of its initiative – has clearly paid off. It has created the conditions that would make Peru an ideal country in which to undertake a nationwide scale-up of SDM and to study the sustainability of such an effort. There is readiness on the part of all parties, and commitment on the part of the MOH, but there are inadequate resources to move forward at this time. In any follow-on project to the AWARENESS project, Peru should definitely be in the forefront of consideration for a true test of the potential for going to scale with SDM and other FAMs in a national family planning program.

Appendix 9 (c)
Rwanda Country Visit Summary: Cynthia Steele

Visit dates: February 26 – March 4, 2006

Activities:
Met with staff of USAID, Ministry of Health, CAs based in Rwanda, and local NGOs. Visited two provinces and met with providers at various levels (hospital, health clinic, community-based) in MOH and NGO service settings. In the North, met with health promoters and users of the method in Bungwe and religious leaders in Mukono. In the South, met with CBD agents of ARBEF (IPPF affiliate) and community leaders in Musambira. Observed several role plays of service provision.

Rwanda: Relevant Data
Rwanda is very densely populated with its 8.6 million people living in a country the size of Maryland. The genocide and civil war had huge impacts on the health system and including pronatalist attitudes on the part of the government and many people. Preliminary data from the 2005 DHS show :
Modern contraceptive prevalence of 10.3% (up from 4 % in 2000)
SDM was included in the DHS and represented .5% of CPR (had the survey been done later when 20 additional sites were added, it would have been even higher)
Percentage of married women who want no more births was 42% (up from 33% in 2000).

IRH in Rwanda
IRH initiated SDM activities in Rwanda in late 2002, in response to a request from USAID/R. IRH has worked closely with the major reproductive health bilaterals managed by Intrahealth (and in fact is co-located with its CAPACITY project) and with JSI/Deliver, which manages logistics in country. Currently the office has a staff of four.

Studies and Activities
IRH initiated SDM work in 13 pilot sites, which were chosen based on representation of the range of service delivery outlets common in Rwanda (FBO, NGO, public sector), being part of Intrahealth's network and in USAID/R's priority areas. IRH provided training, cyclebeads and job aids.

An assessment conducted in late 2003 revealed high levels of client and provider satisfaction, and of client use. Of note, 96% of women interviewed were first time family planning users. Over 19% of couples reported using condoms during the 12 fertile days, contrasted with 4% condom use in the 2000 DHS. Couples reported improved communication on FP matters, most intended to continue using the method, they were able to manage the fertile period, and almost all (especially women) were able to correctly identify their fertile days.

It also revealed that 28% of providers had some difficulties offering SDM—the main issues were discussions of sexuality and the menstrual cycle, and the length of time to conduct counseling. AWARENESS /Rwanda made some modifications in training based on this information. The researchers and AWARENESS disseminated the findings of research at a national level, and then at

the districts where the research was conducted, to maximize the learning at all levels, and to facilitate making any needed changes.

This evidence of success resulted in adding 15 additional sites to offer SDM, as well as the inclusion of Rwanda in IRH's multi-country impact study—adding an additional 40 SDM sites in 2005. These additional sites were chosen based on demand, dynamism of health teams, cultural factors similar to existing sites to assist research comparisons. The research entails use of the knowledge improvement tool (KIT) to assess provider knowledge, mystery clients to assess quality of services (comparing pill and injectables as well), spot checks and supervisory visits with MOH supervisors. The impact study will be completed in May 2007, following a community study in December 2006, to assess attitudes, knowledge and practices of women and men in the study areas. One of the challenges of conducting research in a country as small as Rwanda is the difficulty finding true controls, as sites learn quickly available in neighboring areas.

IRH/Rwanda has actively participated in national family planning activities, such as the family planning working group, the Repositioning Task Force, the IEC Committee. It has also produced radio spots, flyers, articles for the WHO publications in country. Nearly 3000 professionals (providers, trainers, community health workers etc.) have received their materials. Colleagues interviewed reported that IRH staff are very competent, reliable and communicative.

USAID/R included SDM as an indicator in its most recent RFA, and as a result Intrahealth included scale-up in its workplan, which also augers for greater dissemination in other countries by Intrahealth. The production of training materials and job aids, and client information materials in French yielded a resource for use or adaptation elsewhere in Africa and in Haiti.

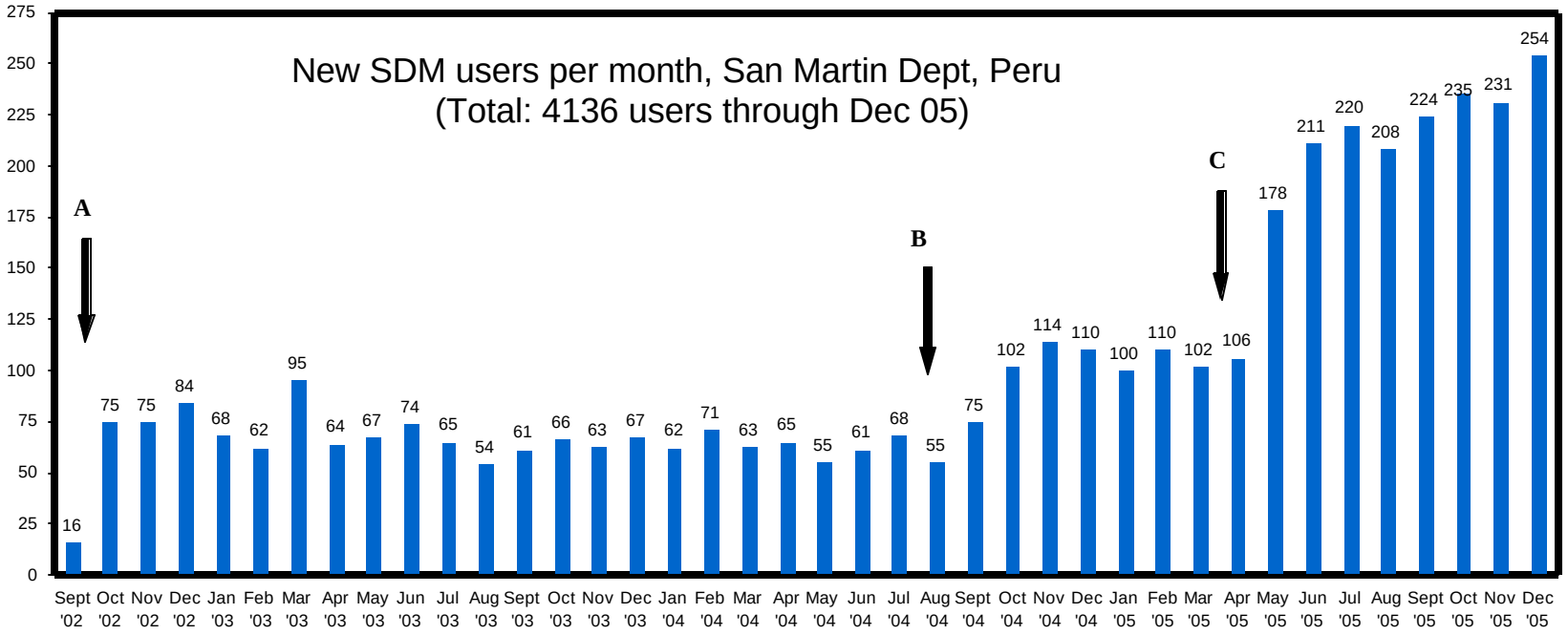
Recommendations

Rwanda is well positioned for scale-up of SDM in country. The following factors argue for such: its low CPR prevalence; positive history of male involvement in FP; religious leaders including some direct involvement; small size allowing easier transfer of knowledge. The main challenge in the short term is the recent redistricting and decentralization of health responsibilities, which has reduced MOH counterparts in the short-term and caused some upheaval in roles, and the lack of inclusion of CBs in the countrywide logistics system.

There is great potential to introduce SDM through the Capacity and Twubekame projects which are expanding geographically, and with PSI which is to expand its social marketing work, to work more closely with religious leaders and communities, to introduce a story line on SDM into the country's popular soap opera produced by Health Unlimited, to test inclusion of FAM into premarital counseling (something USAID/R is interested in). There is also potential to test the two-day method (an estimated 80% of women are ineligible for SDM).

Funding should be more assertively sought from USAID/Rwanda, which has contributed field support for IRH/Rwanda's activities, but has not been asked to cover many of the local costs. It is important to present the total costs of the program, including those covered by IRH directly so that there is a clearer picture of investment and by whom. As the future program in Rwanda will relate primarily to expansion, it makes sense for field support to cover a greater share.

Appendix 10
Effects of Provider Training and MIS Training on Peru SDM Users



A: August 02: initial SDM training by IRH for 103 providers from 63 MOH sites in 2 provinces
B: August 04: MOH trainers started training providers from neighboring provinces (180 providers from 107 sites)
C: April 05: SDM training for 98 providers from 46 sites in 2 provinces, plus MIS training

Appendix 11
Draft Summary of IRH Evaluation: Key Findings

The AWARENESS Project, conducted since 1997 by the Institute for Reproductive Health of the Georgetown University, was evaluated by a team of three consultants. Key findings are summarized below (see full report for recommendations and details).

IRH has fulfilled its objectives in a short time with a small staff and has earned recognition as global leader in Fertility Awareness Methods (FAM); it is universally well regarded and respected. More time and effort are needed to conduct critical research, particularly related to scale up, and to mainstream FAM into FP programs. Key achievements are:

- The Standard Days Method (SDM)[3], developed in 2002, has been shown to be almost 90% efficacious in preventing pregnancy in typical use.
- The development of the Cyclebeads "necklace" for SDM was a highly creative, user-friendly means to teach and use the method and has helped generate interest.
- SDM is acceptable, easy to use and can be taught easily to women/couples by a broad range of professional and community providers of both sexes, whether literate or not.
- A large number of support materials in English, French, Spanish and Hindi (and other local languages) have been developed and distributed.
- The TwoDays Method (TDM), a method based on simple self-observation of cervical secretions, has proven to be equally effective (90%); operations research has lagged, as SDM was prioritized.
- IRH's rigorously conducted research, praised by experts, led to the acceptance of FAM as modern methods by leading international agencies.

Numbers of providers and users

IRH has worked in 25 countries with varying intensity. IRH estimates that there are:

- 150,000 to 200,000 SDM users worldwide, with expected tripling in the next year.
- It has trained (directly or indirectly) 10,000 providers and 5,000 community based promoters
- The great majority of users were not using any method in the two months preceding SDM initiation, and continuation rates have been comparable to other methods.

SDM has clear advantages in addressing unmet need, especially in low CPR countries: it is attractive to new FP users, may serve as a bridge to other modern methods, does not require re-supply (i.e. it is not affected by stock-outs), gets men's participation in FP and promotes couple dialogue; and offers an opportunity to train in and legitimize condom use within marital relationships.

Important barriers remain for the introduction and expansion of SDM:

- Biases by decision makers and providers that it is ineffective, labor-intensive, tied to religious proponents and too complicated for uneducated women (all of which are incorrect).

[3] A method for women with regular menstrual cycles, where the woman/couple abstain (or use condoms or other forms of protection) during the 12 fertile days; The Cyclebead necklace aids women/couples in tracking their cycles.

- A dependence on CycleBeads availability. CycleBeads have a low annualized cost compared to many other methods, but are perceived by some as expensive, and also are not on USAID and UNFPA commodity lists, which complicates their procurement and supply in country.

IRH is now poised to undertake and study much wider scale up in countries that meet key criteria: interested public and private sector partners, a significant unmet need for FP; USAID/Mission support/funding. Furthermore, FAM may be well suited for particular settings and populations that are considered challenging for many other methods: fragile states; countries with low CPR, rural, indigenous and tribal populations etc.

A significant research agenda remains to develop understandings for program scale up. Priorities include understanding conditions for and costs of SDM scale up; effects of introducing FAM on user behaviors, male involvement and other method uptake (preliminary research indicates that it may also increase use of OCs, condom and IUDs); developing and testing CycleBeads alternatives; and assessing the potential for TDM in broader FP programs.

The evaluation team recommends a follow-on project to solidify accomplishments on SDM, including its widespread integration into broad FP/RH programs. Without dedicated focus, progress on FAM will likely be eroded. In addition to completing research, a follow on project would allow scale up to large populations in sentinel countries. For this effort, level or increased funding, field support for non-research efforts and non-USAID based funding will be essential.

Appendix 12
Alternative Project Mechanisms (Pros and Cons)

A.Competitive versus Noncompetitive Process

PROs:

- Can ascertain other interest
- Viewed as an objective process
- May reveal alternative approaches
- Avoids possible perception of special treatment

CONs:

- IRH has clearly demonstrated its
- unique competence
- Allows a seamless transition between the current
- project and the next without losing momentum
- Raises political profile of FAM and may attract
- attention from more controversial NFP groups
- High level of effort for USAID and bidders

B. Placement within Research versus within Services Division

PRO´s of Placement in RTU:

- Significant research agenda yet to complete
- Allows focused attention to learning lessons while
- simultaneously scaling up
- More core funding needed to do needed research, TA and
- global leadership

CONs of Placement in RTU:

- Perception of not needing field support because
- core inhibits attracting Mission funding
- Less awareness of FAM and in services
- projects and divisions, challenging uptake

PROs of Placement in Services

- More regular, ongoing contact with service
- Division staff and CAs to facilitate mainstreaming
- More fluid sharing of better practices

CON´s of Placement in Services

- Insufficient core funding and capacity to do needed
- Research
- Most Missions not yet sufficiently convinced of FAM to

- provide field support
- Mainstreaming might not happen

C. Dedicated Project versus Integration into Broader Project

Integrated into multimethod/service Project

PRO:

- Scale up will be facilitated by projects with experience in services scale up
- Models long-term goal of method integration

CON:

- Insufficient focus before FAM is mature enough to take hold, will backslide. SDM (much less TDM) is still quite young and doesn´t yet have program traction.
- FAM research, lessons learned during selected scale-up will provide needed information for integration by generalists.