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Task-Shifting of Couples Family Planning Counseling and LARC Promotions to Animateurs de Santé in Kigali, Rwanda

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Abstract

Task-Shifting of Couples Family Planning Counseling and LARC Promotions to Animateurs de Santé in Kigali, Rwanda

By Emily Kehoe

Background: Projet San Francisco (PSF), a branch of the Rwanda Zambia HIV Research Group (RZHRG), has been conducting HIV research in Kigali, Rwanda since 1986. With the majority of sero-conversions occurring in heterosexual discordant couples, PSF initiated Couples Voluntary Counseling and Testing (CVCT), which has now become the standard of care in more than 90% of government clinics. PSF is now looking to combine CVCT and family planning services as a means of increasing knowledge and uptake of Long-Acting Reversible Contraceptives (LARC). This project seeks to test the feasibility of administering Couples Family Planning Counseling (CFPC) within the existing infrastructure of community health workers in Rwanda.

Project objective*:* To increase demand creation for LARC services through a task-shifting effort involving increased focus on training Animateurs de Santé (ADS) to administer CFPC sessions, allowing for increased time for nurse-administered LARC insertions.

Methods*:* Two focus groups, comprised of 6-7 Family Planning ADS each, were held at Kabuye and Butamwa clinics in Kigali, Rwanda. CFPC training materials from Zambia were adapted and revised to a level appropriate for ADS in Rwanda. Two pilot training sessions were conducted at Kabuye and Butamwa clinics and the uptake of LARC methods was monitored through an incentive-based invitation system linked to both clinics and ADS. Feedback on the pilot was obtained through focus groups and questionnaires, which was then used to update training materials and procedures.

Deliverables: Deliverables include a comprehensive training guide for CFPC and LARC promotions training for ADS. Also included are recommendations for increasing the utility of ADS-administered CFPC services and uptake of LARC among couples wishing to limit fertility or delay pregnancies. Information will be used by RZHRG to guide further studies and inform future revisions of the ADS CFPC and LARC promotions training tools.

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Table of Contents

List of Acronyms

ADS- Animateur de Santé

ANC- Antenatal Clinics

CBP- Community Based Provision

CBD- Community Based Distribution

CBRHA- Community-based Reproductive Health Agent

CHPS- Community-based Health Planning and Services

CHW- Community Health Worker

CFPC- Couples Family Planning Counseling

CVCT- Couples Voluntary Counseling and Testing

DHS- Demographic and Health Survey

HEW- Health Extension Worker

HIV- Human Immunodeficiency Virus

HTC- HIV Testing and Counseling

LARC- Long-Acting Reversible Contraceptives

MDG- Millennium Development Goals

MoH- Ministry of Health

OCP- Oral Contraceptive Pills

PBP- Performance Based Payment

PSF- Projet San Francisco

RZHRG- Rwanda Zambia HIV Research Group

TFR- Total Fertility Rate

VHT- Village Health Team

WHO- World Health Organization

ZEHRP- Zambia Emory HIV Research Project

Chapter 1: Introduction

Introduction and Rationale

As a result of Projet San Francisco's (PSF) work in Rwanda, Couples Voluntary Counseling and Testing (CVCT) is now the standard of care in government clinics, but misconceptions about long-acting reversible contraceptive (LARC) options have prevented their widespread uptake and have inhibited the subsequent benefits of decreased unwanted pregnancies and safer conception among HIV-discordant couples. Accompanying this are provider hesitancies, limited supply and socially ingrained stigma. Couples Family Planning Counseling (CFPC) seeks to address the need for combined HIV and family planning services. In recent years, Animateurs de Santé (ADS), Rwanda's Community Health Workers (CHW), have received extensive training through the Ministry of Health (MoH) to deliver oral contraceptive pills (OCPs) and injectable contraceptives in homes. PSF has identified a unique opportunity to expand this training to include CFPC and the promotion of LARC methods.

Problem Statement

Although Animateurs de Santé have received family planning training and are currently delivering injectables and OCPs they are not trained to promote LARC methods, which are more effective options for individuals wishing to delay or limit pregnancy for 3 or more years. Clients who are now receiving OCPs or injectables in their communities are no longer exposed to LARC method options at clinics, as they visit less frequently. There is also a need for combined HIV and family planning services that CFPC would address.

Purpose Statement

The purpose of this project was to develop a comprehensive training guide that can be used to train ADS to administer CFPC and promote LARC methods at the community level.

Research Question:

- Can Animateurs de Santé be trained to administer CFPC and LARC promotions at the community level?

Objective:

To increase demand creation for LARC services through a task-shifting effort involving increased focus on training Animateurs de Santé to administer CFPC sessions, allowing for increased time for nurse-administered LARC insertions.

Aims:

1. Assess the role of ADS in CFPC and LARC promotions
2. Identify ADS who are currently trained in basic family planning services that can be trained in CFPC and LARC promotions
3. Simplify the Zambia CFPC training and flip chart to a level appropriate for ADS
4. Monitor the ability of ADS-administered CFPC to recruit potential LARC clients at the community level

Significance Statement

This research will help to fulfill unmet combined family planning and HIV counseling needs in a way that utilizes existing infrastructure to create a sustainable delivery model. Task-

shifting to ADS will increase the awareness and provision of LARC methods, ultimately reducing unwanted pregnancies and improving the overall health and wellbeing of couples.

Definition of terms

Animateur de Sante: Community Health Workers that are trained by the Rwandan Ministry of Health in various health domains including nutrition, sanitation and hygiene, maternal and child health, and family planning.

CFPC: Couples are counseled on family planning options tailored towards the couple's sero-status. They are asked to consider fertility goals and what is best for them as a couple.

Community: Geographic regions associated with clinics.

Comprehensive Training Guide: The final deliverable of the project. This document serves as a guide for organizing materials associated with CFPC and LARC promotions trainings for ADS through Projet San Francisco in Kigali, Rwanda. Organized into two categories, it includes all tools for the training, and the materials related to monitoring and data.

CVCT: "Couples are tested for HIV and results are shared with the partners together. Counselors help the couples to develop a plan to protect each other, depending on whether the couple is concordant (those who share the same results) or discordant (those having different test results)" (Rwanda Zambia HIV Research Group, 2013).

Family Planning: Allows couples and individuals the ability to achieve desired birth spacing and family size.

LARC: Long-Acting Reversible Contraceptives

- IUD- Intrauterine device that can prevent pregnancy for up to 12 years.
    - Copper or hormonal
- Implant- sub-dermal implant that can prevent pregnancy for up to 5 years.
    - Jadelle- effective up to 5 years
    - Implanon- effective up to 3 years

Chapter 2: Literature Review

This is exploratory research, and there are limited sources on the feasibility of ADS to delve further into the provision of family planning services in Rwanda. This section will serve as a background report to provide context to the country as a whole, the organizations involved in HIV and family planning services and the role of ADS in Rwanda. In addition, existing examples will be discussed including ongoing work in Rwanda, as well as similar programs in other countries.

Background

Rwanda is a landlocked country in central and east Africa, with an area totaling 26,338 square kilometers (Institut National de la Statistique du Rwanda (INSR) Measure DHS and ICF Macro, 2011). In addition to the capital city of Kigali, the country is divided into four provinces: North, South, East and West. Provinces are then subdivided into 30 districts, 416 sectors, 2,148 cells and 14,837 villages (Institut National de la Statistique du Rwanda (INSR) Measure DHS and ICF Macro, 2011). According to 2014 estimates, the population has reached over 12.3 million, making it the most densely populated country in Africa (Central Intelligence Agency, 2014). Based on these figures, there are upwards of 467 inhabitants per square kilometer.

Being the most densely populated country in Africa, public health and family planning efforts bear an increased significance in Rwanda. This is especially true in the case of HIV, where the majority of sero-conversions occur among heterosexual discordant couples. Since 2012, HIV prevalence among adults has remained at around 3% (Central Intelligence Agency, 2014). However, the Demographic and Health Survey (DHS) of 2010 indicated that HIV prevalence was up to three times higher in urban areas than in rural areas (Institut National de la

Statistique du Rwanda (INSR) Measure DHS and ICF Macro, 2011). The highest HIV prevalence was found in the capital, Kigali, with 7.3% of those 15-49 years old being HIV-positive (Institut National de la Statistique du Rwanda (INSR) Measure DHS and ICF Macro, 2011). The Total Fertility Rate (TFR) ranges from 3.0 to 5.4, with higher rates in rural areas and among those with lower levels of education (Institut National de la Statistique du Rwanda (INSR) Measure DHS and ICF Macro, 2011). With the average TFR being 4.7 children per woman, HIV and family planning services are primary and interrelated concerns in Rwanda.

Projet San Francisco

Recognizing that the majority of new HIV infections occurred in heterosexual partnerships, with the infection coming from either a spouse or a long-term partner, Projet San Francisco (PSF) pioneered CVCT which has now been adopted nationwide in antenatal clinics (ANC) (Rwanda Zambia HIV Research Group, 2013). CVCT involves testing couples for HIV together and providing sero-specific counseling based on the outcome of the tests as a means to prevent new infections. Although Rwanda is unique in that CVCT is the standard of care in upwards of 90% of all government ANCs, there remains a disconnect between HIV services and family planning services. After the initial CVCT session, men are largely left out of family planning dialogues and education. However, recent PSF studies indicated that there was close to universal interest in CFPC among couples.

Through an NIH-funded study, PSF aims to bridge this gap by pioneering CFPC, which encourages couples to consider their fertility goals and family planning desires together, as a couple. CFPC promotes an increased knowledge of all reliable contraceptive options to couples,

including LARC among couples that wish to prevent pregnancy for 3+ years and dual methods practices, the use of a LARC method and condoms, among discordant couples.

Family Planning Strategic Plan 2012-2016

Support for an increased focus on LARC methods is evidenced by Rwanda's Family Planning Strategic Plan for 2012-2016. The Ministry of Health's strategic plan is a culmination of various countrywide and international efforts and projects including, but not limited to, the Millennium Development Goals (MDGs), the DHS and Vision 2020. These projects aim to identify and combat health issues with goals of improving the overall health and wellbeing of the country. For example, family planning efforts aid in the pursuit of all MDGs, in areas such as the improvement of maternal and child health, the eradication of extreme poverty, and the improvement of environmental sustainability (Government of Rwanda Ministry of Health, 2012). Likewise, reducing the TFR would help achieve the Vision 2020 goals of becoming a middle income country, raising the life expectancy to 66, and reducing the country's aid dependency level (Government of Rwanda Ministry of Health, 2012).

The overall goal of the Strategic Plan is to increase the use of modern contraceptives to 70% by 2016, "through a programmatic framework supporting sustainable service quality, normative demand and an enabling environment" (Government of Rwanda Ministry of Health, 2012). The most frequently adopted modern contraceptive methods in this context include male condoms, OCPs, injectables, implants, and IUDs. The related objectives deal with assuring supply, creating demand, building a supportive environment, and identifying and applying innovative techniques that support effective practices in family planning (Government of Rwanda Ministry of Health, 2012).

Already, the country has seen a drastic increase in the use of modern contraceptive methods. From 2005-2010, the use of modern methods rose from 10% to 45% (Government of Rwanda Ministry of Health, 2012). Subsequently there has been a decrease in the TFR from 6.1 to 4.7 over the same time period (Institut National de la Statistique du Rwanda (INSR) Measure DHS and ICF Macro, 2011). To continue this trend, the Ministry of Health has enlisted ADS to more actively promote family planning methods in and among the communities.

Animateurs de Santé

Animateurs de Santé have played an active role in the health and wellbeing of communities since the Ministry of Health established the program in 1995. At the community level, they have provided services for maternal and child health, hygiene and sanitation, nutrition, and preventative health. Since late 2010, ADS have been trained to partake in the Community Based Provision (CBP) of family planning services throughout Rwanda (Family Health International, 2011). This model has been successful in other countries, including Madagascar, Malawi, Zimbabwe and Ethiopia (Family Health International, 2011). ADS have undergone extensive training through the Ministry of Health that allows them to counsel and provide contraceptive methods including OCPs, injectables, condoms and beads. This has eased the burden on the clinics as well as made the use of family planning services easier for clients.

According to the 2010 DHS, 26% of women surveyed stated that distance to a health facility was a limiting factor in their decision to uptake a modern contraceptive method, which is an issue CBP is seeking to reduce (Institut National de la Statistique du Rwanda (INSR) Measure DHS and ICF Macro, 2011). Another factor to consider is that approximately 19% of married or cohabiting women have stated an unmet need for modern contraceptive methods (Government of

Rwanda Ministry of Health, 2012). To address this, the Ministry of Health trained and mobilized a subset of the 45,000 ADS to increase the use of modern contraceptive methods, follow evidence-based practices that support effective contraceptive supply, stimulate demand and create a supportive environment (Government of Rwanda Ministry of Health, 2012).

As a part of the Ministry of Health's training, selected ADS receive a 10-day training that covers family planning methods, nation-wide health indicators, the reproductive system, hygiene, and guidance on how to counsel couples and individuals. The training outlines specific terms of reference for the Animateurs de Santé, which includes a section on referring to health centers new cases, those wishing to switch methods, and those who want to restart a method. This applies to the methods with which they are trained to distribute, but not LARC methods, which is where this new intervention lies.

Despite its success, there are existing gaps in this CBP system where improvements could be made. First and foremost, LARC methods are widely ignored within the realm of ADS work. They are briefly mentioned in the training, but few details are provided and ADS are not advised to counsel on the benefits or refer interested clients to clinics. Secondly, they can only provide services to those who have already initiated services through a health care provider (Family Health International, 2011). This limitation rules out the possibility of doing promotional or referral-based work for LARC methods. By training ADS to administer CFPC and promote LARC methods, this task-shifting effort would be in line with the Ministry of Health's 2012-2016 Strategic Plan for Family Planning.

Supporting Literature

Ethiopia

Ethiopia stands as an example of where the task-shifting of family planning services has been both studied an implemented. The Ethiopian Ministry of Health sought to shift the provision of methods such as injectables to CHWs, as a means of reaching women in rural areas that had a high unmet need for modern contraceptive methods. They claim this distribution model, the systematic delegation of tasks to less skilled providers, is not new. What is new however, is the increased need for these services to be delivered just as safely and effectively as when provided by medical staff (Prata, 2011).

At the onset of the study in 2008, Ethiopia's health care system was comprised of highly skilled health care providers, Health Extension Workers (HEWs), and Community-based Reproductive Health Agents (CBRHAs). CBRHAs, who most closely resemble Rwanda's family planning-trained ADS, are lay health workers who can distribute OCPs and condoms. They would refer clients interested in injectables to HEWs, who were trained in providing intramuscular injectables. The Ministry of Health's National Reproductive Health Strategy for 2006-2015 is seeking to task-shift this service to CBRHAs. A non-randomized community invention trial was conducted, and women were self-selected into HEW or CBRHA family planning groups. The results of the study found that CBRHAs could effectively administer injectables, and that clients were less likely to discontinue use, most commonly attributed to the convenience of CBP (Prata, 2011).

The World Health Organization (WHO) has reviewed evidence on this delivery model in 9 countries, and found that "with adequate support and skills training, community health workers can administer injectable contraceptives as safely and effectively as facility-based providers" (Prata, 2011). However, further research on the demand for LARC methods through this model has not been explored.

Ghana

A study conducted in southern Ghana sought to determine the effect of the Ghanaian Ministry of Health's nationwide Community-Based Health Planning and Services (CHPS) policy on male involvement in reproductive health and family planning services. The CHPS system was implemented to reduce barriers to health care access, including family planning services. Through a series of focus groups and in-depth interviews, it was found that spousal approval in contraceptive decisions was frequently required (Baba Adongo, 2013). They also found that males were more involved in family planning services when communities had a functioning CHPS system. In order to meet reproductive health targets within this specific cultural context, involving males in family planning dialogues at the community level was proven to be effective and result in better health outcomes for those involved. The study also found that the community health volunteers had minimal knowledge of family planning services, which was an area identified for improvement.

Uganda

Uganda is another example of where the integration of family planning and HIV testing and counseling services at the community level has been explored. In partnership with USAID and the Ugandan Ministry of Health, FHI 360 implemented and evaluated HIV testing and counseling (HTC) by Village Health Team (VHT) members, Uganda's CHWs. The overall goal of the program was to determine if VHTs could safely and effectively provide both HIV testing and family planning counseling services at the community level in two geographically and socially distinct districts. The VHTs had to be trained in and currently delivering family

planning services, including contraceptive injectables, to participate. More so than in previous examples, an increased emphasis was placed on providing accurate test results and ensuring the safety of the VHTs conducting the HIV tests (Family Health International, 2014).

Through surveys and in-depth-interviews with community members and VHTs in early 2013, they were able to assess the impact of the program and identify areas for future improvement. Overall, they found that this adapted service delivery model was successful and VHTs could efficiently and effectively provide HTC services at the community level. However, only 21% of tested clients were tested as a couple, and 25% of VHTs reported having difficulty reaching men (Family Health International, 2014). There was no promotion of LARC services, which is an area consistently lacking in community-level family planning delivery models.

Multi-country review of community-based distribution of injectables

A review of the community-based distribution of injectable contraceptives in four sub-Saharan African countries was conducted and provides a comprehensive overview to the utilization of existing CHW systems in the realm of family planning services delivery. The countries included in the analysis were Uganda, Madagascar, Nigeria and Kenya. These countries were selected because of their pre-existing community-based family planning programs that were run by a subset of trained CHWs (Hoke, 2012).

The appeal to such programs is that they improve access to under-served communities through an informal, yet qualified, chain of delivery. This increases the accessibility of services to these populations, and reduces the burden on clinics. Most current family planning systems allow CHWs to provide OCPs and condoms, but injectables are less frequently provided. This

study sought to provide evidence for the capability of CHWs to safely administer injectable contraceptives after training, despite lacking clinical credentials.

Most of the challenges identified included limited clinicians' availability to supervise, the timely resupply of resources and reporting difficulties (Hoke, 2012). Although significantly supported by external donors, the programs were supported by each country's respective Ministry of Health, indicating that in the absence of external funding, the Ministry of Health would ideally prioritize these issues. In Rwanda, PSF is seeking to build upon these findings, and expand the role of CHWs further to involve the promotion of LARC methods, which once administered, are both more effective and cost-efficient.

Chapter 3: Methodology

Parent Study

This project falls under the broader constructs of RZHRG as a whole, and is a subset of PSF's work in Kigali. Specifically, this project serves as a follow up to a previous study conducted at PSF in the summer of 2013. The project served as foundational research for the NIH-funded CFPC study, examining couples' knowledge, attitudes and practices surrounding family planning and LARC methods. It sought to gauge how couples would receive CFPC and to identify major barriers to LARC uptake. The results from the study indicated an overwhelming majority of couples were interested in CFPC. These findings informed this project, addressing whether or not ADS can be trained to administer CFPC and LARC promotions in addition to their existing tasks within communities.

NIH Grant

PSF has conducted previous NIH-funded work surrounding CVCT, which lead to the successful adoption of CVCT as national policy in government ANCs (Rwanda Zambia HIV Research Group, 2011). Moving forward, they are shifting the focus to the integration of HIV prevention and fertility management strategies. This process involves three specific aims, of which the ADS CFPC pilot trainings falls under Aim 3 (Table 1). The training process, if successful, will be expanded and used as a recruitment strategy for Aim 3 requirements.

For Aim 3, 1200 fertile couples, 300 of each sero-status combination (M+F+, M+F-, M-F+, M-F-), will be recruited from infant vaccination clinics and will be offered CFPC and LARC counseling. Couples will be selected from urban, rural, Catholic and non-Catholic clinics. The goal is to tailor this counseling to their fertility desires and to help them make the best choice for

them, as a couple. This prospective cohort will be followed for three years, with both quantitative and qualitative assessments occurring periodically.

Throughout this process PSF hopes to prevent unplanned pregnancies, perinatal HIV, and associated maternal mortality through LARC provision. Dual use, the use of LARC methods and condoms, in discordant couples will also be promoted. Lastly, there will be a focus on preventing sero-conversion among couples wishing to conceive.

NIH Aim 1	Conduct a formative evaluation of knowledge, attitudes, practices, and objective outcomes – including government policies or guidelines and funded programs – related to HIV prevention, family planning, LARC and safer conception among stakeholders including government officials, international and bilateral funding agencies, and implementing partners. (Years 1-5)
NIH Aim 2	Perform a formative evaluation of attitudes and practices related to HIV prevention, family planning, LARC, and safer conception among nurses in urban and rural, Catholic and non-Catholic clinics (Year 1).
NIH Aim 3	Investigate contraceptive method selection, dual method use, and safer conception strategies as a function of HIV status, fertility goals, clinic type (urban/rural, Catholic/non-Catholic), ARV use, and evolving national guidelines, following provision of integrated CVCT and family planning – including LARC and safer conception counseling – to 1200 couples (300 HIV M+F+; 300 M+F-; 300 M-F+; and 300 M-F-) recruited from infant vaccination clinics and followed for three years, with targeted interviews and focus groups prior to enrollment and during follow-up (Years 1-5).

Table 1: NIH Grant Aims, (Rwanda Zambia HIV Research Group, 2011).

Project Site and Study Population

The project site includes two of PSF's partner clinics, Butamwa and Kabuye, both rural, non-Catholic clinics. Clinics not included in NIH Aim 3 were used for the pilot study, as to not influence the future recruitment process. These specific sites were chosen because PSF had the contact information for their family planning-trained ADS. The study population included ADS

who had previously received the Ministry of Health's family planning training, heads of the ADS, family planning nurses, and additional clinic staff.

If successful, this delivery model will be expanded to include recruitment for the NIH Aim 3 couples in PSF's partner clinics. This includes urban, rural, Catholic and non-Catholic clinics throughout Kigali. The 8 clinics providing CFPC that will be involved are Biryogo, Corunum, Kinyinya, Nyacyonga, Gikondo, Kimironko, Kabusunzu and Masaka.

Research Design

This was a mixed-methods study comprised of focus groups, nurse-led training sessions, pre- and post-training assessments, and post-pilot evaluations and recommendations. Piloting of a CFPC delivery system at two clinics was conducted and data collection occurred between May and August of 2014.

Project Procedures and Data Collection*:*

Upon arrival, rotations were conducted through the PSF departments, which included observing the medical team, lab procedures, administrative staff, data management and a variety of day-to-day tasks and activities within the clinic. CVCT sessions and LARC insertions were observed to become familiarized with the specifics of the differing sero-specific counseling messages. The input and knowledge of the nurse counselors was invaluable, and provided additional insight and a broader picture of CFPC and the work of ADS, most of which would have been lost due to language barriers. From this informed knowledge, a focus group guide to assess ADS' perceptions about LARC methods and CFPC was drafted.

Focus Groups

Two focus groups were conducted at Butamwa and Kabuye clinics, with 6-7 family planning ADS each. Butamwa's focus group took place on 2 July 2014, and 7 ADS and the head of ADS were present. Kabuye's focus group took place on 3 July 2014, and 6 ADS and the head of ADS were present. ADS were selected using "snowball recruitment", which utilizes social networks and key-informants in the selection process (Hennink, 2007). ADS signed an informed consent document before participating in the focus group, which took approximately one hour. Participants received a small transportation reimbursement for their time and participation.

The focus group was conducted in Kinyarwanda by a PSF CVCT counselor who was trained on the specifics of the guide beforehand. An additional staff member was present to take notes and answer any questions. Observing but not speaking the language, notes were taken on impressions, body language and reactions to each question. Debriefing with the counselors occurred after the conclusion of the focus group, and further analysis occurred after the recordings were summarized and reviewed.

Trainings

With the information gained from the focus groups, tools for the training were developed and adapted. The training PowerPoint and flip chart were adapted from Zambia's "Happy Client" model, which was used to train clients who successfully use and would recommend a LARC method. The flip chart is a tool in which clients can see one side, typically a picture or diagram, and the ADS can see the opposite side which outlines notes and points to emphasize throughout the session. A pre- and post-training test was also adapted to assess the knowledge of the ADS before and after the training. A new training assessment was also drafted to help identify areas

for improvement within the training's structure and facilitation. Finally, an invitation system was orchestrated that allows for ADS to conduct CFPC in communities and refer couples to clinics for free LARC services. These invitations are linked to the ADS by an identification number and allow their performance to be tracked and incentives to be distributed. A performance based payment (PBP) system was predicted to be the most effective payment method.

After the tools were approved and translated, pilot trainings were held at Butamwa and Kabuye clinics. A nurse counselor and a CVCT counselor led the trainings at both clinics. Community-level CFPC and LARC referrals began the week after the trainings, and followed a structured distribution plan. Clinic visits occurred the weeks following the trainings to observe incoming referrals and discuss CFPC experiences. Nurses were also consulted to see how they thought the program was going. Returned invitations were tracked and recorded in a pilot data invitation tracking sheet (Appendix I).

Upon the conclusion of the first phase of invitation distribution, follow-up meetings were held at each clinic to gauge the successes and identify areas for improvement. At the conclusion of the pilot a, one-on-one assessments and a post-pilot focus group were conducted with the ADS. The information obtained from these allowed for the necessary revision of training materials and procedures before the scale-up of the model.

Data Analysis

The qualitative data from the focus groups was recorded and summarized in debriefing sessions after the conclusion of the focus groups. Notes were taken and main themes and issues were organized into a summary report (Appendix II). This included similarities and differences found in the responses of ADS at both Butamwa and Kabuye.

The training sessions were observed and notes were taken. Similar to the focus groups, translations were summarized and a summary report was compiled (Appendix II). The report included notes, pre- and post-test scores, training assessment results, and comments from the ADS. From training data and post-pilot data, next steps, recommendations and a comprehensive summary were drafted and presented to the staff at PSF. Returned invitations were monitored by in-country staff after departure and the analysis was finalized at Emory University during the fall and winter semesters. The post-pilot focus groups and questionnaires were summarized and analyzed by in-country staff and forwarded to the Emory office.

Human Subjects and Ethical Considerations

This study was included on the existing RHZGH Emory IRB protocol #357-2004, and those involved were categorized as study staff members. CITI certifications pertaining to GCP, Biomedical Human Subjects and Social/Behavioral Research were completed before arrival in country. SOP modules and their corresponding quizzes were also completed. In field, consent forms in Kinyarwanda were administered before focus groups.

Limitations

There were several limitations to this study design and the procedures followed. The most notable limitation was the site selection process. The pilot training sites were selected because of the availability of ADS contact information at the two clinics. Both sites were rural and non-Catholic, which could be a concern if the experiences and opinions at urban or Catholic clinics differ significantly from non-Catholic clinics. However, this convenience sample is typical in such a study, because there are 20 clinics in Kigali, 8 of which were previously set aside for NIH

Aim 3. Another potential source of selection bias exists in the way couples were recruited for CFPC. The couples recruited were selected by the ADS, and it is likely convenience sampling was used. This can decrease the generalizability of findings, in that the recruited couples may not be representative of the entire community population.

Trainings were attended by all ADS, although one individual at Kabuye did not attend the focus group session. This could have skewed results if the other ADS gained additional information from the focus group. However the perceived likelihood of skewed results from this is minimal.

There are also limitations associated with using an incentive-based project. When cash incentives are involved there are opportunities for misconduct and emphasis on quantity over quality. Finally, language was a barrier and therefore a limitation of the study. Not speaking Kinyarwanda may have resulted in miscommunication and missed information on occasion. Having nurse-counselors debrief meetings and trainings in English after their conclusion mitigated this concern.

Chapter 4: Results

Focus Groups

The focus groups were able to provide a sense of what family planning-trained ADS are currently doing in the communities, their knowledge of LARC methods, and their opinions on the acceptance and feasibility of the uptake of LARC promotions. The results are organized into common themes and differences by clinic.

Common Themes

1. Mothers come to the ADS for family planning services including pills and injectables, rather than the ADS going out to visit the mothers.
2. ADS most frequently visit women for family planning services, rather than men or couples, because they provide pills and injectables, which only require the woman to be present.
3. ADS are not familiar with the mode of action/mechanism of LARC methods. It is also not clear to them that the methods are easily reversible.
4. Perceived nurse resistance to removal was mentioned in both groups. They also stated that there is a prohibitive fee for removal of a LARC method.
5. Both groups exhibited the belief that the nurse who removes an IUD or implant has to be the same nurse that inserted it.
6. Both groups were willing to do the trainings, and wanted to be involved in the process. However, it would likely interfere with the tasks they are already performing. It is more work, with nothing in return for them unless an incentive is provided.

Differences

Butamwa

1. Mothers are not flexible with scheduling and can be unkind about it.
2. They had the misconception that mothers can conceive with implant. Part of this was attributed to issues with the expiration dates on the implants.
3. ADS believed that promotions should be done frequently, in a variety of locations and manners (roads, markets, radio, billboards, health posts, community centers, television, churches, community service events, weddings, high schools, meetings, homes, celebrity events).
4. Religious concerns were stated here, but not at Kabuye.
5. Requested additional PSF staff to help with the LARC insertions.

Kabuye

1. No scheduling problems were stated.
2. They said that the community doesn't like LARC methods, for reasons mentioned in both groups (reversibility unknown, have to pay for removal, need the same nurse to remove it, etc.). However, those at Butamwa never directly stated that the community does not like LARC methods.
3. They had no concerns about the uptake of LARC promotions in addition to their existing duties as ADS.
4. Family planning nurse and head of ADS believed their staff could handle the additional LARC insertions.

Overall, both clinics were receptive to the idea of involving ADS in LARC promotions. It was indicated that having ADS in the clinics would not cause any problems. After conducting

both focus groups, it was clear that the ADS at Kabuye had a lower level of family planning knowledge than those at Butamwa. They answered many proposed ideas "yes" but asked very few questions and lacked the engagement seen at Butamwa. As a result, the focus group at Kabuye finished 20 minutes earlier than the focus group at Butamwa. Their knowledge of LARC methods was lower as well. However, this was not reflected in the results of the returned invitations, indicating that the training was comprehensive.

Trainings

The results of the training include observations, pre- and post-test scores and individual assessment responses. Overall, the trainings were successful, without any major complications. Participants were involved and asked frequent questions, and improvements were seen in pre- and post-test scores across both groups (Table 2).

ADS	Pre-test (x/10)	Post-test (x/10)
BUTAMWA		
ADS 1	6	9
ADS 2	8	9
ADS 3	6	9
ADS 4	8	9
ADS 5	9	9
ADS 6	9	10
ADS 7	4	8
KABUYE		
ADS 1	6	7
ADS 2	6	9

ADS 3	8	9
ADS 4	7	9
ADS 5	9	10
ADS 6	7	9
ADS 7	6	8

Table 2: Pre-and post-training test scores

Table 2 shows the pre- and post-training test scores for all ADS who underwent the CFPC/LARC promotions training. There was near universal improvement of scores, aside from one participant who achieved the same score on both tests. The most frequently missed questions were as follows:

1. Jadelle and IUD are more effective methods at preventing pregnancy compared to which methods?
2. If the couple is interested in selecting a LARC method following their session, the counselor should answer the questions they feel comfortable answering, and refer to the LARC nurse for more technical questions. True or False?

From the assessment, it was found that the majority of participants said they understood 85% or more of the information presented (Appendix II). Many participants indicated that they needed more training, and said they would benefit more from a 2-day training, as the 1-day training was very long. Most indicated that CFPC was new and they would have liked to spend more time on it, which will be adjusted for in future trainings. Similarly, several suggested that PSF hold refresher trainings because this information is new to them, and they feel it would help them better understand the material. Furthermore, they suggested that someone from PSF come into the communities with them to monitor how they are doing.

One individual suggested a role-play section of the training in which they could go through the actions of counseling couples with specific fertility goals. A "case studies" section was included in the original training, but this new component would be more interactive and would allow them to practice using the flip chart and get immediate feedback from those administering the training. Having run through potential scenarios will allow them to feel more confident when out promoting in the communities, which will in turn ease the concerns of the community members.

Pilot Invitation Tracking Results

From our incentive-based invitation tracking system, PSF was able to monitor how many invitations were handed out, how many were returned, and what services were provided for the invitations. Initially, lower success was seen at Butwamwa due to clinic staff issues that arose. Once full capacity for LARC provision was established, a second phase was established, with each ADS receiving 5 invitations, as in phase 1. Those at Kabuye received 10 invitations for phase 2, due to the success of the first phase. Tables 3-10 show the distribution of invitations by clinic, ADS, phase and LARC method received.

Table 3 shows how many invitations each ADS was given at each respective clinic, how many of these invitations were returned, and what LARC services were obtained for these returned invitations. *Tables 4-9* break down the number of invitations returned and what services were received by phase and clinic. Finally, *Table 10* shows the results of the pilot as a whole, combining invitations returned for both Butamwa and Kabuye clinics.

Health center	ADS ID	Number of invites given	Number of invites returned	Larc provided		
				IUD	Jadelle	Implanon
BUTAMWA	BUT 001	5	0	0	0	0
	BUT 002	5	1	0	1	0
	BUT 003	5	0	0	0	0
	BUT 004	5	2	1	1	0
	BUT 005	5	5	4	1	0
	BUT 006	5	0	0	0	0
	BUT 007	5	2	2	0	0
BUTAMWA PH 2	BUT 001	5	3	0	3	0
	BUT 002	5	4	0	4	0
	BUT 003	5	3	1	2	0
	BUT 004	5	4	1	3	0
	BUT 005	5	5	0	5	0
	BUT 006	5	4	3	1	0
	BUT 007	5	3	1	2	0
KABUYE	KAY 001	5	2	0	2	0
	KAY 002	5	4	0	4	0
	KAY 003	5	2	0	2	0
	KAY 004	5	5	0	1	4
	KAY 005	5	4	1	3	0
	KAY 006	5	5	2	3	0
	KAY 007	5	5	2	3	0
KABUYE PH2	KAY 001	10	7	0	3	4
	KAY 002	10	7	2	0	5
	KAY 003	10	6	1	0	5
	KAY 004	10	7	1	1	5
	KAY 005	10	7	2	2	3
	KAY 006	10	8	2	0	6
	KAY 007	10	9	2	2	5
TOTAL		**175**	**114**	**28**	**49**	**37**

Table 3: Pilot training invitation period, by clinic, ADS, phase, invitation and LARC type

Butamwa Phase 1 Returned:	10/35.0	**28.6%**
IUD:	7/10.0	**70.0%**
Jadelle:	3/10.0	**30.0%**
Implanon:	0/10.0	**0.0%**

Table 4: Returned invitations by LARC type, Butamwa phase 1

Butamwa Phase 2 Returned:	26/35.0	**74.3%**
IUD:	6/26.0	**23.1%**
Jadelle:	20/26.0	**76.9%**
Implanon:	0/26.0	**0.0%**

Table 5: Returned invitations by LARC type, Butamwa phase 2

Butamwa Returned:	36/70.0	**51.4%**
IUD:	13/36.0	**36.1%**
Jadelle:	23/36.0	**63.9%**
Implanon:	0/36.0	**0.0%**

Table 6: Total returned invitations by LARC type, Butamwa all

Kabuye Phase 1 Returned:	27/35.0	**77.1%**
IUD:	5/27.0	**18.5%**
Jadelle:	18/27.0	**66.7%**
Implanon:	4/27.0	**14.8%**

Table 7: Returned invitations by LARC type, Kabuye phase 1

Kabuye Phase 2 Returned:	51/70.0	**72.9%**
IUD:	10/51.0	**19.6%**
Jadelle:	8/51.0	**15.7%**
Implanon:	33/51.0	**64.7%**

Table 8: Returned invitations by LARC type, Kabuye phase 2

Kabuye Returned:	78/105.0	**74.3%**
IUD:	15/78.0	**19.2%**
Jadelle:	26/78.0	**33.3%**
Implanon:	37/78.0	**47.4%**

Table 9: Total returned invitations by LARC type, Kabuye all

Total Returned:	114/175.0	**65.1%**
IUD:	28/114.0	**24.6%**
Jadelle:	49/114.0	**43.0%**
Implanon:	37/114.0	**32.5%**

Table 10: Total returned invitations by LARC type, Kabuye and Butamwa

These results indicate that the ADS were successful in the recruitment of couples for LARC services at the community level. Kabuye in particular saw high rates of returned invitations with 77.1% of invitations returned during phase 1 and 72.9% of invitations returned during phase 2. Due to clinic staffing issues, Butamwa's initial phase saw only 28.6% of invitations returned. After sorting out these issues, and assuring the clinic was able to take on the additional clients from ADS recruitment, a second phase was initiated. This phase saw higher rates of success, with 74.3% of invitations being returned for LARC services. Interestingly, of the total pilot period, Butamwa had the highest rate of returned invitations for IUD services, with 36.1% of couples choosing IUDs. At Kabuye, only 19.2% of couples chose IUDs, leaving the vast majority choosing an implant, either Jadelle or Implanon.

In all, of the 175 invitations handed out to couples across both communities, 65.1% of invitations were returned for a LARC method. For piloting a new delivery model, these are impressive results. During the short pilot phase, 114 individuals, who might not have been reached otherwise, were able to receive LARC services. By seeing the breakdown of which LARC methods were obtained and by discussing the results with ADS, areas for improvement can be identified. For example, perhaps there was lower uptake of IUDs because of commonly held misconceptions about the method. To address this, ADS can be trained to effectively dispel myths about this method, so the clients can make informed decisions that are best for them as a couple.

In conclusion, the success of the pilot training sessions and invitation period has exceeded expectations. PSF will adapt materials and plans to scale-up the model, continuing to use ADS in future CFPC and LARC promotions activities.

Post-pilot Focus Group and One-on-One Questionnaire

Questionnaire

A one-on-one questionnaire was conducted with ADS from both sites after the conclusion of the pilot phase of the study. It included both multiple choice questions as well as open-ended responses. The questionnaire sought to gain an understanding of how CFPC was conducted, determine how ADS were engaging with the communities, and identify existing challenges. The questionnaire and focus group guide can be found in the training guide in Appendix I, while the responses can be found in Appendix II.

Results of the questionnaire showed that 86% of ADS reported that they generally initiated the conversation on LARC with clients, and 71% reported speaking with the couple together at least once. Approximately half of the invitations were given out at the couples' homes, after an average of 2 visits. Meeting lengths varied, but the majority (36%) of ADS reported the LARC promotion meetings lasted approximately 16-30 minutes each. One of the most striking findings was that 86% of ADS reported meeting with clients on two separate occasions before the client accepted the invitation.

Part of the survey was aimed at identifying challenges and areas for improvement. 71% of ADS reported that initiating a conversation with a client who had never used a family planning method before was "somewhat challenging". From the open-ended responses, it was found that one of the greatest challenges in both sites, was that women had prior misconceptions

about LARC methods. From a logistical standpoint, it was suggested that the clinic's capacity for handling LARC insertions needs to be improved, refresher trainings should be held for ADS, and the incentive amount per referred couple should be increased.

Focus Group

The focus group provided the opportunity to explore in more detail the issues brought up in the questionnaire. ADS were able to discuss lessons learned by recounting their personal experiences in the communities. Lessons learned dealt with how to best approach a couple and initiate a conversation, how often to visit homes, and the best strategies for promotion. The agreed upon most important points to emphasize during promotions were:

1. Promoting that LARC methods work for long periods of time and the subsequent benefits
2. Promoting the benefits of IUDs, including that they are non-hormonal, last longer than implants, and typically have fewer side effects
3. ADS can give personal and positive experiences concerning LARC methods while emphasizing the availability of staff to address concerns, side effects, or method change
4. The benefits of LARC versus the upkeep of short-term methods, such as injectables and OCPs

In addition to these points, challenges were discussed. ADS stated that it was challenging to approach individuals they were not familiar with in the village, because of the personal nature of the conversation. Also important to note, is that families are typically not accustomed to being

visited by ADS at their homes, which can create additional hesitancies. Some families expressed concerns that ADS were only promoting because of the incentives involved. ADS also confirmed that there was a high level of misunderstanding of LARC methods among community members.

To address these challenges, ADS were advised to be consistent in their home visits and have patience when couples are skeptical. Next, they were told to never promote something they are not knowledgeable about, but rather to refer couples to clinic staff for additional information. Avoiding the provision of false information allows for greater trust, and the couple will be more willing to learn about LARC methods. Although knowing the client before discussing LARC methods is beneficial, they were told that promoting to strangers and newcomers to the communities is possible if done in an appropriate way.

Recommendations

Finally, the ADS made recommendations for future trainings. These included:

1. Increase the incentive per returned invitation
2. Hold regular refresher trainings for ADS
3. Provide transportation incentives for couples to visit clinics for LARC methods
4. Increase nursing staff at clinics
5. Train additional ADS at each clinic.

Training Revision

Taking into consideration all recommendations thus far, in-country staff made several changes to training materials and procedures. First, the training was restructured to be a 2-day

event. The first day now has an expanded CFPC session, which includes a step-by-step process for ADS when promoting LARC and CFPC to the clients.

Many of the concerns brought up by ADS after the pilot phase dealt with challenges in interacting with couples. To address this role-play scenarios were suggested by the ADS and subsequently added to the second day of training. Common scenarios will be conducted with each ADS as an applied practice for the field following their didactic training on the first day. ADS will rotate through roles as a woman, man, or ADS in each role play scenario. Scenarios include examples that were brought up as challenges by the ADS in focus groups and questionnaires. Challenges include addressing reluctant clients, those with previous negative contraceptive experiences, those with potential religious conflicts, couples with many children, and those with misconceptions about LARC methods. After the ADS recommend their "next step" solution for the scenario, the instructor will give feedback.

Finally, the incentives were increased from 500RWF per returned invitation to 1000RWF. This was proposed by the ADS because transportation and time were concerns as they were having to visit clients' homes multiple times rather than the anticipated single visit. Additional concerns beyond those addressed thus far are being considered and will be addressed in a practical manner.

***Deliverables**:*

The deliverable is an ADS CFPC/LARC Comprehensive Training Guide, which can be used to establish and carry out trainings. All components, including focus group and training tools, and monitoring and data information can be found in Appendix I. When applicable, Kinyarwanda versions of tools can be requested. Included in the guide are:

I. **Tools and Training (English)**:
   a. Focus Group Discussion Guide
   b. ADS CFPC/LARC Promotions Training Material and Procedures
   c. Training PowerPoint
   d. CFPC/LARC Flip Chart
   e. Training Pre- and Post-Test
   f. Individual Training Assessment

II. **Monitoring and Data**:
   a. ADS Contact Spreadsheet
   b. ADS Training Information Spreadsheet
   c. ADS Training Logistics and Invitation Description
   d. Invitation Template
   e. ADS Follow-up Meeting
   f. Pilot Data Invite Tracking Sheet
   g. Post-Pilot Focus Group
   h. Post-Pilot One-on-One Questionnaire

Chapter 5: Discussion

The overall goal of this study was to determine whether or not ADS could be trained to successfully administer CFPC and LARC promotions at the community level. A training manual was developed and the feasibility of this delivery model was assessed through two pilot trainings.

Public health implications

This study has shown that ADS are capable of being trained in LARC methods and administering CFPC. We saw improved scores after trainings, and 114 of 175 invitations were returned. Given these results, we can say that this new delivery method for CFPC and LARC promotions has public health implications on several levels.

First, the individuals being reached are often part of vulnerable populations that normally would not be reached or have access to these services. Introducing them to their full range of contraceptive options in a setting outside of clinics allows for individuals who may already be receiving OCPs or injectables, and therefore not visiting the clinic as often, to learn about more effective contraceptive methods available. Addressing couples together allows for sero-specific counseling which will reduce the incidence of sero-conversion among discordant couples.

Concerning the implications of this study for PSF, task-shifting CFPC and LARC promotions to ADS will free up the time for nurses to do LARC insertions. This will allow clinics to work more efficiently and will allow the maximum number of patients to receive services. By involving community members and ADS in the health infrastructure of family planning and HIV services, there is a greater sense of ownership of these efforts and therefore an increased likelihood for sustainability. In addition to this, having ADS counsel couples can serve as a recruitment strategy for PSF's NIH Aim 3 couples.

Finally, this study has the potential to affect family planning services and delivery for the country as a whole. Looking forward, it is possible that this training module could be included in the family planning curriculum the Ministry of Health provides to ADS. In the long run, increasing access to these services will aid in reaching the goals of the Family Planning Strategic Plan laid out by the Ministry of Health. Increasing accessibility to services will likely result in the uptake of services, which will reduce the TFR and prevent the spread of HIV.

Moving Forward

With the success of the pilot training and invitation period, PSF plans to use ADS-administered CFPC in future activities. This will include CFPC as a group intervention and recruitment strategy in NIH Aim 3 clinics as well as CFPC in communities at non-NIH Aim 3 clinics as was tested in the pilot. After taking into consideration the results of the pilot and the ADS' recommendations, steps have been taken to make this a more efficient and successful program. The training materials have been revised and the format of the training itself has been adjusted. In addition to these changes, there are several recommendations to consider.

From a logistical standpoint, information sessions should be held with the heads of ADS from all 8 NIH AIM 3 clinics before continuing to use this delivery model. Holding a meeting before trainings will allow the invitation system to be explained beforehand, reducing the likelihood of miscommunications and misunderstandings. It is also important to maintain communication with the ADS to increase the sustainability of the partnership. As a part of this, holding refresher trainings and establishing a system to monitor and evaluate community-level CFPC would be beneficial. This could involve having a nurse counselor visit communities to

monitor how CFPC is being conducted. Similarly, nurse counselors could visit clinics and meet with those who are bringing in invitations to discuss how they thought CFPC went.

Conclusion

The trainings at Butamwa and Kabuye clinics served as a pilot session testing the feasibility of ADS-administered CFPC and LARC promotions. This delivery method, which has proven successful in other sub-Saharan African countries, was innovative in the context of Rwanda. Similar CHW family planning programs in countries such as Ghana, Ethiopia and Uganda provided a foundation of evidence for the feasibility of the CBD of family planning methods.

Contributing factors to the success of the pilot were Rwanda's pre-existing system of ADS, PSF's expertise and well-established relationship with clinics in Kigali and the surrounding areas, and the dedicated staff members conducting the trainings. A main limitation of the study was that it was piloted in two rural, non-Catholic clinics; meaning results may not be representative of all clinics.

The number of invitations returned and the continued interest in the program has given supportive evidence that this delivery method could be sustainable and scaled up. Based on feedback, training materials were adapted and the structure of the training session was altered. With continued efforts and research, the program will evolve to cover additional clinics, and will therefore increase access to LARC methods for more individuals throughout Rwanda.

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APPENDICES

Appendix I:

ADS CFPC/LARC Comprehensive Training Guide:

This document serves as a guide for organizing materials associated with CFPC/LARC promotions trainings for Animateurs de Santé (ADS) through Projet San Francisco (PSF) in Kigali, Rwanda. The documents listed were used in 2 pilot trainings, to test the feasibility of ADS administered CFPC in Kigali as part of a task-shifting effort to allow more time for nurses to insert LARC methods. The overall goal is to utilize ADS in the process of recruiting couples through CFPC for PSF's NIH AIM 3 study. Organized into two categories, you can find the tools for the training, and the materials related to monitoring and data. Tool copies and data shells have been included for formatting purposes; original files, data shells, and Kinyarwanda versions can be obtained upon request.

III. **Tools (English)**:

a. Focus Group Discussion Guide
b. ADS CFPC/LARC Promotions Training Materials and Procedures
c. Training PowerPoint
d. CFPC/LARC Flip Chart
e. Training Pre- and Post-Test
f. Individual Training Assessment

IV. **Monitoring and Data**:

a. ADS Contact Spreadsheet
b. ADS Training Information Spreadsheet
c. ADS Training Logistics and Invitation Description
d. Invitation Template
e. ADS Follow-up Meeting
f. Pilot Data Invite Tracking Sheet
g. Post-Pilot Focus Group
h. Post-Pilot One-on-One Questionnaire

I. Tools
a. Focus Group Discussion Guide (Version: 25 June 2014)

Focus Group to address ADS perceptions about CFPC and LARC
Good Morning Everyone,

Welcome to our discussion. I want to thank you all very much for coming today. My name is _____, and I will be asking you some questions today about your activities in family planning.

Let us begin today by introducing ourselves; please tell us your first name.

Okay great, now I'm going to ask you some general questions about your experiences with family planning.

1. What family planning related activities do you conduct in your work as an Animateur de Santé?

2. In your work, do you provide family planning services to individual women or couples more frequently?
    a. Where have these promotions taken place- In the home, in groups, community gatherings?

This is _____, who will be taking notes during our session; and this is Emily, who will be observing. Projet San Francisco would like to train Animateurs de Santé at health centers to provide CFPC and LARC promotions. This research is sponsored through a grant from the US National Institutes of Health. The purpose of our meeting today is to discuss and get your feedback on the opinions and experiences of Animateurs/Agents de Santé concerning CFPC and LARC promotion.

We chose you for today's group because we want to learn about your beliefs and opinions concerning family planning and LARC methods. We would like to hear about your experiences with family planning methods, both personal and during your work as an Animateur de Santé. It is not necessary that you all agree with one another or have the same opinions. The goal of our discussion today is to understand the variety of views that exist about family planning, so we hope that you will share how you truly feel.

During today's discussion we want to make sure that all of you are able to express your opinions, so feel open to sharing with us. You do not need to speak in any particular order, but please speak to the group as a whole. We want to hear what each of you has to say, so please speak loudly and do not talk at the same time as others. We also hope that you will respect each other's opinions. I am just here to guide the discussion, and know that there are no right or wrong answers.

This research will be used to improve CFPC and LARC promotion training sessions for Animateurs de Santé in Rwanda. No one outside of our research team will hear what you say. Additionally, we hope that you will not share the information that is shared today by our group members.

Today's discussion will last approximately 60 minutes. Because (note-taker) won't be able to write down everything you say, we will be recording today's session. We will now review the informed consent for today's discussion and you can decide whether or not you would like to give us permission to record you today. At any point in the discussion you are free to leave or withdraw consent.

Does anyone have any questions?

(Informed Consent)

Now we will be discussing Long Acting Reversible Contraceptive (LARC) methods specifically.

3. What do you know about LARC methods (IUDs and Jadelle)?

4. Do you have any doubts or concerns pertaining to LARC methods?

5. Why might people be hesitant to adopt a LARC method?

6. What strategies do you think can be used to address these concerns that limit LARC uptake?

7. Where would be the best place to do LARC promotions?

8. Do you have any concerns about the uptake of LARC promotions in addition to your existing tasks?

Thank you so much for contributing to today's discussion. It sounds like (*summarize main points of discussion*) are the most important issues for you.

Does anyone have anything they would like to add?

Thank you again for your contribution. We hope it will help to understand the experiences of Animateurs de Santé concerning Family Planning and LARC promotion.

Have a great day!

b. ADS CFPC/LARC Promotions Training Materials and Procedures

Materials Needed for Training:

- Training PowerPoint
- Flip chart
- Folders for each ADS
    - Hard copy of training PowerPoint
    - Flip Chart
    - Notebook
    - Pen
- LARC invitations
- Projector and laptop
- MoH FP flip chart
- IUD an Jadelle
- Poster-sized paper, tape, scissors
- Sign in sheet
- Transportation reimbursement log and incentives
- Pre- and post-test
- Individual training assessment
- Refreshments and snack

Training Procedures:

1. Introductions
2. Draft expectations and norms
3. Introductory slides
4. Administer pre-test
5. IUD/Jadelle slides
6. Myths and misconceptions slides
7. Break
8. Explain flip chart
9. Explain invitation system
10. Administer post-test
11. Individual training assessment

Post-training procedures:

- Enter information into ADS tracking spreadsheet
- Follow up meeting with ADS at conclusion of invitation period
    - Post-pilot focus group and one-on-one questionnaire

c. Training PowerPoint (Version: 9 July 2014)

3/25/2015

Training Slides for ADS CFPC

Training for ADS on Couples Family Planning Counseling (CFPC) and Long Acting Reversible Contraception (LARC):

Projet San Francisco

Welcome and Introduction

- Name
- Village
- Clinic
- What do you want to learn today?

Why We're Here

- This training will cover:
  - Couples family planning counseling (CFPC)
  - Long acting reversible contraception (LARC) services

Objectives

- Learn how to provide couples family planning counseling (CFPC)
- Learn about long-acting reversible contraception (LARC) methods
  - Efficacy
  - Safety
  - Mechanisms
  - Myths
- Understand the benefits of LARC and learn how to provide information about LARC services to clients
- If you have any questions during the training, please ask them

Introduction

- From your previous training, you have already learned about family planning counseling, reproductive health, hygiene, and safety. Specifically concerning:
  - Pills
  - Injections
  - Condoms
  - Beads
- In addition, we want to introduce you to two long acting reversible contraceptive methods:
  - IUCD (The loop)
  - Jadelle (Implant)
- Couples Family Planning Counseling (CFPC) allows for the man and woman to decide as a couple on which family planning method is best for them

Introduction to CFPC

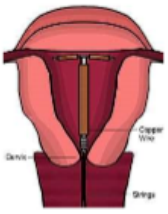
- Couples Family Planning Counseling
- Allows couple to:
  - discuss fertility goals (number of children they would like to have and when they want to have them) together and decide on family planning needs together
  - decide on a method together
  - dispel myths directly
  - feel confident about family planning choice
- When integrated with LARC promotion, it allows couples to make family planning decisions and receive the method for free the same day

Introduction to LARC

- Long Acting Reversible Contraception
- Two methods: copper IUD/IUCD (the loop) and contraceptive implant (Jadelle)
- Long lasting
  - IUCD effective for 12 years
  - Implant effective for 5 years
  - No need to return to clinic every 3 months!
  - Inserted at clinic for free
- Completely reversible
  - Quick return to fertility
  - Can have removed at any time
  - Removed at clinic for free
- User-independent
  - Don't need to remember to take anything!
- Highly effective
  - Better at preventing pregnancy than pills or injectables
  - Very low failure rates
- Safe
  - Low risk of complications

IUCD (Intra-Uterine Contraceptive Device)

- You have learned about reproductive organs in previous trainings, and you can see here that the IUD is inserted into a woman's uterus through the cervix
- It is a small, flexible plastic frame with copper sleeves
- Copper prevents sperm from fertilizing the egg
- Non-hormonal
- Inserted at clinic by a health care professional and takes approximately 10-15 minutes
- User independent, once inserted no need to remember to take anything



IUCD (Intra-Uterine Contraceptive Device)

- More effective at preventing unintended pregnancy than pills or injectables
- Less than 1 woman out of 1,000 will become pregnant in the first year of use. The IUCD is 30 times more effective at preventing pregnancy than injectables
- Appropriate for women who want to wait 2 years or more before conceiving
- Effective for 12 years, or until removed
- Completely reversible, fertility returns upon removal
- Woman can return at any time for free removal
- Sometimes there are short-term side effects as woman's body adjusts: cramping, heavier bleeding, heavier menses
  - If they have more specific questions, refer to clinic staff
- Need to return to clinic after next menses for follow-up
- Woman can check for strings to see if in place, if can't find strings need to return to clinic

True or false?

- The IUCD is effective for a maximum of 8 years
- The IUCD is not a good choice for couples who want to have a child in 3 years
- Upon removal of the IUCD, the woman can become pregnant
- The IUCD uses hormones to prevent pregnancy

True or false?

- The IUCD is effective for a maximum of 8 years
  - False! The IUCD is effective for a maximum of 12 years, or until it is removed
- The IUCD is not a good choice for couples who want to have a child in 3 years
  - False! The IUCD is a good choice for couples who want to delay pregnancy 2 or more years
- Upon removal of the IUCD, the woman can become pregnant
  - True! Fertility return immediately after removal
- The IUCD uses hormones to prevent pregnancy
  - False! The IUCD does not have any hormones. The IUCD prevents pregnancy through the copper acting to prevent the sperm from reaching the egg

Implant (Jadelle)

- Two small, flexible plastic rods inserted into woman's upper arm
- Like pills and injectables, it releases hormones, a type of medicine, into the blood a little bit at a time. This causes the cervical mucus to thicken, which prevents sperm from fertilizing the egg
- Implant is inserted in the clinic by a health care professional
- Inserted via a small incision in the upper arm, the procedure is simple and take only 10-15 minutes
- Rods can not be seen in the arm, but can be felt
- User independent, once inserted no need to remember to take anything

Implant (Jadelle)

- More effective method at preventing unintended pregnancy than pills or injectables
- Less than 1 woman out of 1000 will fall pregnant in the first year of use. The implant is 30 times more effective at preventing pregnancy than injectables
- Appropriate for women who want to wait 2 years or more before conceiving
- Effective for 5 years, or until removed
- Completely reversible, fertility returns a few weeks after removal
- Woman can return at any time for free removal
- Some side effects as woman's body adjusts: dizziness, spotting, irregular bleeding, nausea, missed menses, or mood changes
- If insertion site becomes infected, need to return to clinic

True or false?

- The implant is effective for a maximum of 12 years
- The implant is not a good choice for couples who do not want another child
- Upon removal of the implant, the woman can become pregnant
- The implant uses hormones to prevent pregnancy

True or false?

- The implant is effective for a maximum of 12 years
  - False! The implant is effective for a maximum of 5 years, or until it is removed
- The implant is not a good choice for couples who do not want another child
  - False! The implant is a good choice for couples who want to delay pregnancy 2 or more years. However, the IUCD would be a better choice since it is effective for 12 years instead of 5
- Upon removal of the implant, the woman can become pregnant
  - True! However, it might take a few weeks after removal for the woman's body to adjust and for fertility to return
- The implant uses hormones to prevent pregnancy
  - True! Like pills and injectables, the implant releases hormones, a type of medicine, into the blood a little bit at a time

Myths and Misunderstandings

- Myth: the man can feel the IUCD strings during sex, which can be painful for him
- Truth: it is rare for the man to feel the strings during sex. If he does, they are soft and can not hurt him. If the strings are bothersome, they can be shortened

Myths and Misunderstandings

- Myth: the IUCD can move from the uterus up to the heart, brain, etc.
- Truth: the IUCD can not move up from the uterus. The only way the IUCD can move is if the body expels it out through the vagina (which is rare). Just like how a baby does not move from the uterus, the IUCD will not move from the uterus

Myths and Misunderstandings

- Myth: babies can be born holding the IUCD, or with the IUCD on their head, or with the IUCD on their eye
- Truth: this does not happen. The IUCD is very good at preventing pregnancy, it is very rare to fall pregnant with an IUCD. If a woman does become pregnant, the IUCD can be removed and will not hurt the baby

Myths and Misunderstandings

- Myth: a woman can't lift heavy things with the implant in her arm
- Truth: while the insertion site is healing, a woman should be careful. After this, the implant does not affect what the woman can do

Myths and Misunderstandings

- Myth: if the woman hits her arm on something, the implant can move into her heart, lungs, or brain
- Truth: the implant stays under the skin where it was inserted, it will not move until you want to have it removed

Myths and Misunderstandings

- Myth: these methods will make a woman infertile
- Truth: these methods are completely reversible. Once taken out, you can conceive immediately with the IUCD and within a few weeks with the implant

Myths and Misunderstandings

- Myth: it is dangerous to remove the IUCD, taking it out will cause bleeding and damage
- Truth: removing the IUCD is a very simple and safe procedure

Myths and Misunderstandings

- Myth: the nurse who removes an IUD or implant must be the same nurse who inserted it
- Truth: any family planning nurse can remove a LARC method, regardless of whether or not they inserted it

Myths and Misunderstandings

- Myth: only the nurse can decide when it is right for a woman to have a LARC method removed
- Truth: the client can choose to have the LARC method removed at any time

Myths and Misunderstandings

- Myth: these methods can cause cancer
- Truth: these methods do not cause cancer. In fact, these methods reduce the risk of some types of cancer, such as endometrial cancer

Myths and Misunderstandings

- Myth: when a woman's menses stops because of the implant, the blood can store up in her body and make her sick
- Truth: changes in menses may occur with the implant, but this is a normal, safe side effect. The blood is not stored up in the woman's body

Myths and Misunderstandings

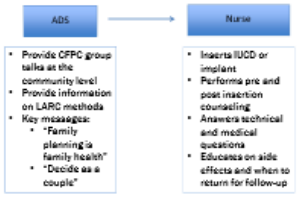
- Myth: the IUCD and the implant can cause a woman to have twins or triplets
- Truth: the IUCD and the implant do not change a woman's chances of having twins or triplets

Myths and Misunderstandings

- Myth: the IUCD can be expelled during urination
- Truth: the urine comes from a different location than where the IUCD is placed; it cannot be expelled during urination

Break

Your Role



Couples Family Planning Counseling

COUPLES FAMILY PLANNING COUNSELING

Structure of Group CFPC

- Introduce IUCD and implant
  - Explain efficacy, reversibility, safety, mechanism, and insertion procedure
  - Remind clients that insertion and removal is free of charge
- **This is not the time for the group to ask questions!**
  - Do **NOT** ask an open ended question such as "what do you know about these methods" in the group!
  - Myths should not be discussed during group counseling! If myths are brought up in the group, it can make some couples needlessly scared
  - However, if someone brings up a myth, you will be able to accurately dispel it
  - The couples will be able to ask questions and discuss myths further with nurse counselors.
- Encourage couples to discuss fertility goals (number of children they would like to have and when they want to have them) and family planning methods as a couple.

Structure of Group CFPC (2)

- Always remember to refer to a clinic nurse or health care professional when you do not know the answer or how to best advise a couple.
- After family planning group counseling, you will refer interested couples to the nurses to provide further information or services by invitation.
  - Invitations will be linked to you by an ID number, clinic code, and date

Case Studies

- A woman says that her sister had a baby who was born with the IUCD on its head. How do you handle this situation?
- A client is worried that her husband will be able to feel the IUCD during sex. How do you handle her worry?
- During family planning group counseling, a woman interrupts and says that her friend became pregnant even though she had an implant. How would you address her comment and bring the session back?
- A couple has detailed questions on side effects. How do you handle their questions?

Questions

- Are there any questions related to the IUCD?
- Are there any questions related to the implant?
- Have you heard any other myths about these methods that were not mentioned?
- Are there any questions on CFPC procedures?
- Are there any other questions?

Flip Chart Review

- A flip chart will be provided to aid you in CFPC and to make sure all of the main points are addressed.
- We will now use this time to hand out and review all pages of the CFPC/LARC flip chart

3/25/2015

Thank you!

- Thank you for attending CFPC/LARC training!
- If you have any questions later, contact the trainers
- Please let us know if you have any suggestions to make this training better

d. CFPC/LARC Flip Chart (Version: 8 July 2014)

ADS Flip Chart Pages for Couples Family Planning Counseling

ADS Flip Chart Pages for Couples Family Planning Counseling

8 July 2014

PSF

Family Planning is Family Health

1 PSF

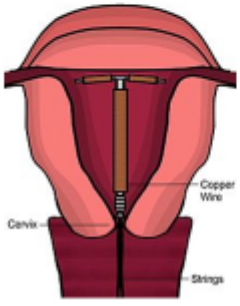
Overview of Family Planning and LARC Methods

- Family planning involves:
  - ✓ Personal health
  - ✓ Child spacing
  - ✓ Family health
  - ✓ Education
  - ✓ Community health
- Child Spacing
  - ✓ Timing pregnancies is very important for health of mother and child.
  - ✓ At least 2 years between children is recommended.
- We're going to be introducing 2 Long Acting Reversible Contraceptive (LARC) methods that will help you plan your family and avoid unplanned pregnancies.
  - ✓ IUCD (the loop)
  - ✓ Jadelle (Implant)
- Both methods can be inserted and removed at the clinic for free

2 PSF

IUCD/Implant

IUCD (The Loop)



Jadelle (Implant)

3 PSF

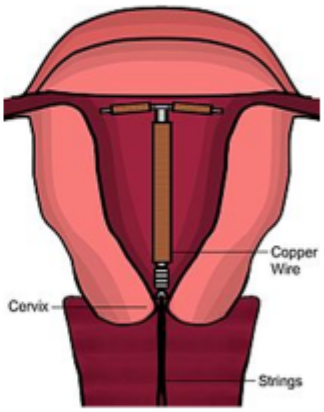
IUCD/Implant

- **Both Methods:**
  - ✓ Very effective methods for preventing unintended pregnancies
  - ✓ 30 times more effective than injectables
  - ✓ Used in other countries for over 40 years
  - ✓ Both methods can be inserted and removed for free at health centers

- **Benefits**
  - ✓ Methods are long lasting; there is no need to return to clinic for refills
  - ✓ LARC methods are completely reversible; the methods can be removed any time the client is ready, and fertility returns quickly.
  - ✓ LARC methods are user-independent; clients do not need to remember to take anything as with pills

4 PSF

Decide Together



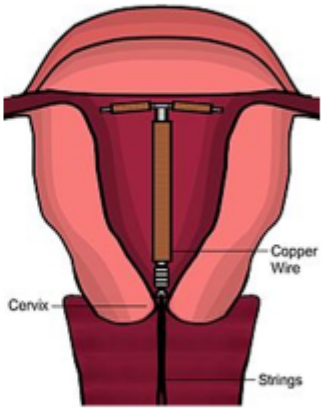
5 PSF

Decide Together

- It is important to discuss your fertility goals as a couple and make a decision together.
- If you want to delay 2+ years, the IUCD or implant, may be a good and safe choice for you to consider as a couple.

6 PSF

IUCD/LOOP



7 PSF

IUCD

- **IUCD Facts:**
  - ✓ The IUCD is inserted into the uterus
  - ✓ Completely reversible, clients can have it removed at any time and be able to conceive
  - ✓ Is effective for up to 12 years if left in place
  - ✓ The procedure takes 10-15 minutes and can be done at the health center
  - ✓ The IUCD doesn't use hormones, it works because the copper prevents the sperm from fertilizing the egg.
- ***Note to ADS:*** *pass out IUCD to clients to feel*
- *This family planning method does not prevent transmission of HIV/STDs, to prevent the transmission of HIV or STDs please use a condom*

8 PSF

Implant

9 PSF

Implant

- **Implant Facts:**
  - ✓ The implant is inserted under the skin in the upper arm
  - ✓ Similar to pills and injections, it releases medicine into the blood a little at a time
  - ✓ Completely reversible, once removed a client can be able to conceive after a few weeks
  - ✓ If left in place it can prevent pregnancies for up to 5 years
  - ✓ The procedure takes 10-15 minutes and requires a small incision in the arm. Medication is used to numb the area to avoid feeling any pain
- ***Note to ADS:*** *pass out implants to clients to*
- *This family planning method does not prevent transmission of HIV/STDs, to prevent the transmission of HIV or STDs please use a condom*

10 PSF

Family Planning is Family Health

11 PSF

Review of Methods

Review:

- The IUCD and implant are now available for free from clinics.
- Importance of a contraceptive method:
  - ✓ If you do not use a contraceptive method, it is likely you will become pregnant.
  - ✓ If you are not ready for a pregnancy, it is best that you decide together what method is best to help you prevent a pregnancy until you are ready for one.
  - ✓ Reiterate the effectiveness of the IUCD and Implant

Wrap Up:

- It is important to consider their fertility goals/family planning needs as a couple
- Clinic nurses will answer any questions you have about LARC methods. *(Please try not to field any questions during the group session.)*
- If you wish to receive one of these LARC methods, you may take this invitation to your local clinic and receive services free of charge.

e. Training Pre-and Post-Test (Version: 15 April 2014)

Name:_____ Nurse ID:_____ ADS ID:_____
Assigned Clinic:_____

Pre/Post Test for ADS CFPC Training

1. What are benefits of Long-Acting Reversible Contraceptives (LARC)?
    a. Women with LARC do not need to regularly visit the clinic for refills
    b. Fertility returns quickly after removal of LARC method
    c. LARC methods do not have to be remembered every day or every time there is a sexual encounter
    d. All of the above
2. Couples Family Planning Counseling allows couples to:
    a. Discuss fertility goals together
    b. Decide on a method together
    c. Feel confident about their family planning choice
    d. All of the above
3. LARC Methods are a good choice for couples who want to delay pregnancy for 2 or more years
    a. True
    b. False
4. After inserting an IUD or Jadelle, women may experience side effects for a few weeks as their bodies adjust. True or False?
    a. True
    b. False
5. An IUD can last up to how many years?
    a. 3
    b. 7
    c. 12
    d. 20
6. The Jadelle can last up to how many years?
    a. 1
    b. 5
    c. 8
    d. 15
7. LARC methods move to other parts of the body such as the belly, heart, or brain once they are inserted?
    a. True
    b. False
8. Which statement is correct?
    a. IUD is non-hormonal; Jadelle Implant is hormonal

   b. IUD is hormonal; Jadelle Implant is non-hormonal
   c. Neither is hormonal
   d. Both are hormonal
9. Jadelle and IUD are more effective methods at preventing pregnancy compared to which methods?
   a. Condoms
   b. Pills
   c. Injectables
   d. All of the above
10. If the couple is interested in selecting a LARC method following their session, the counselor should answer the questions they feel comfortable answering, and refer to the LARC nurse for more technical questions. True or False?
   a. True
   b. False

Pre/Post Test Quiz for ADS CFPC Training ANSWERS

1. What are benefits of Long-Acting Reversible Contraceptives (LARC)?
   a. Women with LARC do not need to regularly visit the clinic for refills
   b. Fertility returns quickly after removal of LARC method
   c. LARC methods do not have to be remembered every day or every time there is a sexual encounter
   d. All of the above
2. Couples Family Planning Counseling allows couples to:
   a. Discuss fertility goals together
   b. Decide on a method together
   c. Feel confident about their family planning choice
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   a. True
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8. Which statement is correct?
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   a. Condoms
   b. Pills
   c. Injectables
   d. All of the above
10. If the couple is interested in selecting a LARC method following their session, the counselor should answer the questions they feel comfortable answering, and refer to the LARC nurse for more technical questions. True or False?
   a. True
   b. False

f. Individual Training Assessment (Version: 27 June 2014)

ADS CFPC Individual Training Assessment

1. What topics were the most interesting to you? (circle all that apply)
    a. Overview of CFPC/LARC
    b. IUD
    c. Jadelle
    d. Myths and misconceptions
    e. Flip chart

2. This training was useful to my work as an Animateur de Santé.
    a. Strongly agree
    b. Agree
    c. Disagree
    d. Strongly disagree

3. Which information presented was new to you? (circle all that apply)
    a. CFPC
    b. IUD
    c. Jadelle
    d. Myths and misconceptions
    e. Flip chart

4. Do you now feel that you understand CFPC and LARC methods?
    a. Yes
    b. Somewhat
    c. No

5. Was the training time sufficient?
    a. No, it was too short
    b. Yes, it was just right
    c. No, it was too long

6. Please leave any suggestions or recommendations for improving the CFPC/LARC training.

_____
_____
_____
_____
_____
_____
_____

II. Monitoring and Data

a. ADS Contact Spreadsheet

X Clinic FP ADS List						
Days and time when two rooms would be available						
ADS First Name	ADS Last Name	Gender (M or F)	Umudugudu	Active since Month/Year	Phone number	Comments

b. ADS Training Information Spreadsheet

Clinic:								
Date:								
N.	Last name	First Name	Year of Birth	Village	Cell	Length of FP work	Pre-test	Post-test
1								
2								
3								
4								
5								
6								
7								

c. ADS Training Logistics and Invitation Description (Version: 8 July 2014)

ADS Training Logistics

We are trying to determine realistically how many LARC insertions the clinics can take on per day as a result of our ADS promotions. One proposed idea includes only training the ADS from the focus groups, so in the case of Butamwa, this would be 7. We would have to schedule the invitations to ensure that the clinic is not overwhelmed and can handle the incoming clients.

If we have 7 ADS, and give then 5 invites each, twice a month this would be 70 invitations per month.

In theory there should be no more than 5 insertions per day for week 1, with slightly fewer in the second week. We need to make this scheduling process clear in the training, so the ADS understand what we are asking. Perhaps a calendar handout with a brief note saying which weeks which ADS should be promoting, as well as the fact that they should try to schedule 1 per day for their assigned week.

WEEK 1 July 21-25:

- ADS 1- 5 invites
- ADS 2- 5 invites
- ADS 3- 5 invites
- ADS 4- 5 invites

WEEK 2 July 28-1:

- ADS 5- 5 invites
- ADS 6- 5 invites
- ADS 7- 5 invites

TOTAL= 35 invites over 2 weeks

If this goes well, we can follow the same distribution model for the second 2 weeks of the month

WEEK 3:

- ADS 1- 5 invites
- ADS 2- 5 invites
- ADS 3- 5 invites
- ADS 4- 5 invites

WEEK 4:

- ADS 5- 5 invites
- ADS 6- 5 invites
- ADS 7- 5 invites

MONTLY TOTAL= 70 invitations

d. Invitation Template

Numero: BUT 001 I 001

Umudugudu: _____

Ikigo Nderabuzima cya _____ kiratumira abashakanye bifuza kugirwa inama no guhabwa servisi zo kuboneza urubyaro ko tubakira kuwa _____ indi minsi ikigo nderabuzima gikurikiza gahunda zisanzwe.

Izina ry'umujyanama w'ubuzima: _____

Tubashimiye uko muzabyitabira!

e. ADS Follow-up Meeting (Version: 21 July 2014)

ADS CFPC/LARC Follow Up Meeting

Purpose:
To ensure that ADS are successfully administering CFPC in communities and distributing invitations for couples to come into the clinics for LARC services.

Address:
1. Lessons learned thus far
2. Strengths
3. Challenges
4. Myths they are encountering
5. Future recommendations
6. Questions

Discuss with staff:
1. What to do with returned invitations
2. How the payment of incentives will be organized
3. How is the staff handling the higher demand of LARC?

f. Pilot Data Invite Tracking Sheet

Health center	ADS ID	Number of invites given	Number of invites returned	LARC provided		
				IUD	Jadelle	Implanon

g. Post-Pilot Focus Group

ADS CFPC/LARC Focus Group- Kabuye and Butamwa

Purpose:

- To hold a verbal, group discussion with Kabuye and Butamwa ADS (14) for each group to learn and reflect from one another's successes or challenges following one-on-one interview.

Address:

1. **Lessons learned**
   a) Could you please share successful stories that you experienced when giving LARC invitations?

   b) How would you compare promoting LARC methods when speaking to a woman only, versus the couple together?
   - Woman only better? How?
   - Couple together better? How?

2. **Strengths**
   a) What was your strategy when approaching particular clients to give LARC invitations? (Religion- Which/Why? Number of children, Single/Married women, Known family issue, Economic.)

   b) What are the two most important key points on a LARC method to emphasize to a woman in order for her to accept a LARC invitation?

3. **Challenges**
   a) What were your first impressions explaining a LARC method to a woman or a couple together whom had no prior family planning method? (Receptive?, Skeptical?, Fear of side effects?)

   b) Were there any other challenges presented to you?

4. **Myths Encountered**
   a) Were there any myths you encountered that you were unsure how to answer? Give examples.

   b) What was the level of knowledge of your community's understanding of LARC methods before ADS promotion? (What this new information? Had they used a LARC method before?)

5. **Future Recommendations**
   a) What advice would you give to another ADS whom is promoting and distributing LARC invitations?

   b) From your field experience, what would you recommend to be added in the training material we used to train on CFPC and LARC promotion?

6. **Questions**

h. Post-Pilot One-on-One

One-on-One Questionnaire for Kabuye & Butamwa ADS

Thank you for participating in this questionnaire. Because many of your invitations were returned to receive a LARC method, we will use this feedback to better understand your strategies in choosing those who received an invitation.

1. How did you choose which client to give the LARC invitation?

2. In general, who initiated the conversation on LARC?
   - You (ADS) (1)
   - Woman (2)
   - Man (3)
   - Couple (4)

3. Did you talk to the couple together or woman alone?
   - Couple together
   - Woman alone

4. In general, where was the location of the invitation given?
   - Couple home (1)
   - ADS home (2)
   - Health center (3)
   - Market (4)
   - Social gathering (5)
   - Other: _____ (6)

5. In general, how long did you spend with the client when discussing LARC methods and the invitation process?
   - 1-15 minutes (1)
   - 16-30 minutes (2)
   - 31-45 minutes (3)
   - 46 minutes-1 hour (4)
   - More than 1 hour (5)

6. Did you ever meet with a client more than one time?
   - Yes (1) If yes, how many times?
     - 2 times
     - 3 times
     - 4 times
     - More than 5 times

No (2)

7. Did you give any group talks?
   Yes (1) If yes, when? _____ (Month and Year)
   where? _____
   No (2)

8. How challenging was initiating a conversation with a client with no prior family planning method?
   Not challenging (1)
   Somewhat challenging (2)
   Very challenging (3)

9. In general, could you describe what kind of challenges did you encountered in distributing LARC invites?

10. How difficult was it distributing LARC invitations?
   Not difficult (1)
   Somewhat difficult (2)
   Very difficult (3)

11. What suggestions do you have for improving the system?

Appendix II:

I. Focus Group Notes
II. Focus Group Report
III. Training Summary Report
IV. Post-pilot Questionnaire Results
V. Post-pilot Focus Group Results

I. Focus Group Notes

Focus Group Summary:

Focus Group #1- Butamwa
Present- 7ADS (3M/4F), head of ADS, vice head of clinic, head ADS,

During consent process- "Why are you coming to learn from us, when you are high up and we are at the low community level"

- Participant asked this and Robertine explained that they are experienced at providing FP at the community level and we are not

Hyacinthe moderated and did informed consent

One ADS was very inquisitive about consent

- New concept to them → people ask their opinions all the time without it
- Paragraph about injury was confusing to them → not really applicable in FG setting

-FG lasted ~50 minutes
-5 more ADS were selected for the training afterwards (6M/6F total)

Summary of responses from Robertine
Q1- FP experiences

- Community likes it but mothers come to ADS; they spend the whole day waiting and lose time for other tasks.
- They don't benefit from it.
- Some mothers are not kind or flexible w/ scheduling
- Like it, but challenging because of time
- Provide primary care to babies (fever, weight, diarrhea)
    - Many activities in community
    - Promoting community level in homes

Q2- ADS provide services more frequently to mothers

- because they gives services such as pills and depo →not initiating services or dealing with new cases
- men see them for condoms though
- refer couples to clinics

Q3- LARC methods

- understood implant
- IUD is effective (10-12 years), good for delaying pregnancy
- Exclusively at health clinics and don't need to use ADS → follow up is at health clinics
- Challenges → women think only the nurse who inserted it can remove it
- **mode of action/mechanism and reversibility missing (need it in training)

Q4-Doubts and Concerns

- Weight gain
- Changes in menstruation
- Libido lowered
- Nurses' resistance during removal
    - Not friendly to remove, may charge to remove
- MoH says FP should be free
    - But on performance based payment system
    - Issue of payment
    - Supplies are not all subsidized and can be expensive
- Misconception that mothers can conceive w/ implant
    - Expiration dates of Jadelle not explained/checked

Q5- Hesitancy to adopt methods

- Removal/failure

Q6- Strategies to address concerns

- Check expiration dates of medical supplies
- To always interview client and help to choose
- Appropriate method based on medical history
- BP & weight
- Increase promotion
    - Community health facility
    - Side effects need to be addressed

Q7-Where should promotions be?

- Everywhere, all the time
    - roads, market, radio, billboard, health posts, centers, tv, churches, umuganda, weddings, high schools, meetings, homes, use celebrities

Q8- Concern of uptake of LARC promotion

- Willingness to help, but they have too many activities and lose time to do their own work
- Poor, gain nothing
- Don't even have soap to wash hands
- Don't have time to earn money to do volunteer work
- Many are farmers, but spend their days waiting for clients
- Losing market time b/c of volunteering

    - Would make 1000 RWF a day but FP work lowers that to 250/day
    - Can't provide food for families
    - Paid by clients via cooperative (PBF)
    - Don't get paid often → no immediate incentive
- Conflicts w/ religious misconceptions
    - Protestant (PEPFAR)
    - Rehoboth
    - Catholics only issue is with abortion

Final thoughts from ADS:

- Incentives monthly, directly to recognize their efforts
- 30,000 per month for promotional work and to compensate
- Confidentiality an issue
    - Have to ask visitors to leave when clients show up
    - Asked for small tent so clients are more comfortable and their homes would not be disturbed
- Need box for medical supplies
- Request training
    - No refresher since FP training/certification
    - No one observes what they are doing → nurses at clinics don't have time to supervise them/handle misconceptions

Logistics

- There is a room and electricity for training (for next week?)
- 5 invites for 12 ADS for 15 days
- 5 more after 15 days → 10/month
- Schedule 1 couple per day =~12 couples a day at health clinic at most
- Have someone from PSF to help out here (counseling, screening, testing, methods)
- 1500 RWF incentive for pilot (pay after 15 or 30 days?)
    - Direct vs. indirect incentives (cooperatives previously)
- Will collect #'s at clinic and we will meet up to evaluate after 1 month
- Promoting in homes
- Invites ARE day specific and scheduled (ideally)
- Be ready when you give out invites – will start quickly

Next Steps:
-Call to get feedback on training materials
-Set date for training
-Discuss supply and demand/resources → they will discuss it at their staff meeting and get back to us

OVERALL:
Very receptive of the idea and are committed and willing to work hard to set the national standard. They will be very active since they are the first group, and want to do well.

Focus Group #2- Kabuye
Present- 6 ADS (2 M/4F), head of ADS

-Met with the head of clinic before FG
-Met with vice head and FP nurse after FG

-Recorded in folder E

-Most participants were answering, but were slightly more reserved than yesterday's group.

-It seemed like they skipped a question or two in the middle, and they finished the discussion after 32 minutes. They had a 20 minute talk afterwards as well.

Summary of responses from head ADS (Cynthia)
Q1- FP experiences
- In villages, homes
- Bed net programs → discussed FP with mothers too
- Very happy providing services
- Easier for community (distance)
- No scheduling problems here, mothers go to ADS

Q2- ADS provide services to mothers more frequently

Q3- LARC methods
- Jadelle lasts 5 years
- IUD lasts 10 years and is non-hormonal

Q4- Doubts or concerns
- Community doesn't like LARC methods
- They last a long time → They may want to conceive before 5-10 years
    - Again the issue of reversibility may not be clear
- Same nurse has to remove the implant that inserted it
- Removal is not easy
- They have to pay 1000 RWF to have it removed
    - To cover clinic expenses (gloves for example)
- Prefer injections/pills

Q5- Strategies for concerns
- Need free removal
- Nurses should be available for removals
- Need training and tool to be aware of FP
    - Want to be knowledgeable before they try to promote LARC in the community

Q6- Where to do promotions

- Village meetings- once a month
- Mothers gather once or twice a month to discuss programs
- Vaccinations/immunizations at clinics
- In charges should help promote

Q7- Concerns about uptake of LARC promotions

- None

Would it be acceptable for ADS to do promotions at clinics as part of a training?

- They are available/willing to
- Clinic would be okay with it
    - They are open 7 days a week, although all services may not be available
    - Only urgent care on weekends

Discussion with vice-head and FP nurse (see Amelia's write up)

ADS need training to do counseling

- Nurses want them to be involved, and there is no problem having them at the clinic

Logistics: 21 FP trained ADS

- Only 3 male ADS, so we can't do equal numbers for training
- Have a room with electricity for training, but typically they never use PowerPoint

Next steps:

- Call FP nurse on Monday to schedule training
- Cynthia (head ADS) is gone next week but here the week after

OVERALL:
It seems like the clinic staff is on board with the idea of involving ADS in LARC promotions. For now, it seems that having ADS in the clinics should not be a problem. However, it was pretty clear that the ADS at Kabuye were not on the same level as the ADS at Butamwa. They answered many proposed ideas "yes" but asked very few questions and lacked the enthusiasm seen at Butamwa. As a result, the focus group finished 20 minutes earlier than the previous. Their knowledge of LARC methods was lower as well. They said that it would be no problem to take on LARC promotions. We will be getting in contact with the head FP nurse on Tuesday to further discuss the pending training.

II. Focus Group Summary Report: ADS Perceptions about CFPC and LARC

A summary of the results from two focus groups held with Animateurs de Sante at Butamwa and Kabuye clinics.

Butamwa: 2 July 2014, 7 ADS and head of ADS present

Kabuye: 3 July 2014, 6 ADS and head of ADS present

Common Themes:

7. The mothers come to ADS for FP services (pills, injectables), rather than the ADS going out to visit the mothers.

8. ADS most frequently visit women for FP services because they provide pills and injectables, which only require the mother to be present.

9. ADS are not familiar with the mode of action/mechanism of LARC methods. It is also not clear to them that the methods are easily reversible.

10. Nurse resistance to removal was mentioned in both groups. They also stated that there is a prohibitive fee for removal of a LARC method.

11. Both exhibited the belief that the nurse who removes an IUD or implant has to be the same nurse that inserted it.

12. Both groups were willing to do the trainings, and wanted to be involved in the process. However it would interfere with the tasks they are already performing. It is more work, with nothing in return for them unless an incentive is provided.

Differences:
Butamwa

6. Mothers are not flexible with scheduling and can be unkind about it.

7. They had the misconception that mothers can conceive with implant. They attributed this to issues with the expiration dates on the implants.

8. Believed that promotions should be everywhere, all the time (roads, market, radio, billboard, health posts, centers, tv, churches, community service projects, weddings, high schools, meetings, homes, celebrity events.

9. Religious misconceptions were stated here, but not at Kabuye.

10. Requested additional PSF staff to help with the LARC insertions.

Kabuye

5. No scheduling problems were stated.

6. They said that the community doesn't like LARC methods, for reasons mentioned in both groups (reversibility unknown, have to pay for removal, need the same nurse to remove it, etc.). However, those at Butamwa never directly said the community doesn't like LARC methods.

7. They had no concerns about the uptake of LARC promotions.

8. Believed their staff could handle the additional LARC insertions.

CONCLUSION: It seems like both clinics are receptive to the idea of involving ADS in LARC promotions. For now, it seems that having ADS in the clinics should not be a problem. After conducting both focus groups, it was clear that the ADS at Kabuye were not on the same level as the ADS at Butamwa. They answered many proposed ideas "yes" but asked very few questions and lacked the enthusiasm seen at Butamwa. As a result, the focus group finished 20 minutes earlier than the previous. Their knowledge of LARC methods was lower as well. They said that it would be no problem to take on LARC promotions, but it was unclear if they really understood the process and what exactly we were asking of them. We will be getting in contact with the head FP nurses and in charges this week to further discuss the pending training.

III. Training Summary Report

ADS CFPC/LARC Promotions Training Summary
Butamwa- 15 July 2014
Start: 10am
Finish: 4:30pm
Facilitators: Robertine and Bella
Present: 7 ADS and head of ADS

Procedures:

1. Introduction and expectations
    a. Know LARC
    b. How to counsel couples about LARC
    c. How to dispel myths
2. Norms during training
    a. Punctuality
    b. Respect each other
    c. Active participation
    d. Silence phones
    e. Make fun!
    f. Ask questions
    g. Learn from each other
3. Introductory slides
4. Pre-test
5. Training slides
6. Break at 12:30pm
7. Myths and misconceptions
8. Flip charts
9. Invitations
10. Post-test
11. Individual training assessment

Notes:

- Group was very interactive during myths section
- Is the red letting in slides typo corrections?
- Should reprint flip charts (did for Kabuye)
- Training was too long, should be 2 days instead of 1
- Will now be referring couples for Tuesdays and Thursdays due to clinic availability
    - ADS 2,3,4 for week 1
    - ADS 1,5,6,7 for week 2
- Given 5 invitations each for first 2-week round, and will return to clinic for second set of 5 for the second 2-week time period.
- Bella discussed discordant couples with them at the end
- Want to maintain partnership and include refresher trainings

Pre- and post-test scores:

- ADS 1: 6, 9
- ADS 2: 8, 9
- ADS 3: 6, 9
- ADS 4: 8, 9
- ADS 5: 9, 9
- ADS 6: 9, 10
- ADS 7: 4, 8

*Most frequently missed questions for both trainings were:

9. Jadelle and IUD are more effective methods at preventing pregnancy compared to which methods?
10. If the couple is interested in selecting a LARC method following their session, the counselor should answer the questions they feel comfortable answering, and refer to the LARC nurse for more technical questions. True or False?

Assessment questions (completed by 9 individuals):

1. What topics were the most interesting to you?
    a. CFPC =6
    b. IUD =7
    c. Jadelle=5
    d. General Info about LARC=7
    e. Flip Chart=3
2. This training was useful to my work as an Animateur de Santé.
    a. All participants strongly agreed
3. Which information presented was new to you?
    a. CFPC = 7
    b. IUD =7
    c. Jadelle =6
    d. General info about LARC =5
    e. Flip chart =4
4. Percent satisfied/understood after training:
    a. 85% or more =5
    b. 75%=4
5. Which section should take more time?
    a. CFPC =7
    b. IUD =2
    c. Jadelle =2
    d. General info about LARC =5
    e. Flip Chart = 2

Assessment comments and suggestions:

- Need additional training
- Incentives and additional training
- Asked for telephone contact between PSF and CHWs → closer ties to PSF
- PSF to be aware and go to village when they promote in order to help them with their promotions

- Trainings every 3 months for a year to help them be more competent with CFPC
- PSF must provide incentives and transportation fees for promotional work because they are far from homes and cover a large area
- 500 RWF incentive is not enough, 1000 is better because life is very complicated these days
- Because it is a new concept, training should be 2 days
- 5000 incentive because they will spend more time visiting because these days life is hard
- More training on how to counsel couples
- Appreciated trainer (Robertine) because she has a very good understanding and was very competent to give the training. She kept sleepy participants awake.
- They should have a time to do role plays on how to discuss and counsel couples and how to counsel groups/communities (2 types)
- More trainings

Kabuye- 16 July 2014
Start: 11:50am
End: 5:15pm
Facilitators: Robertine and Bella
Present: 7 ADS and head of ADS

Procedures:

1. Introduction and expectations
2. Norms
3. Introductory slides
4. Pre-test
5. Training slides
6. Myths and misconceptions
7. Break
8. Flip chart (with Bella)
9. Invitations
10. Post-test
11. Individual training assessment

Notes:

- There was no electricity in the building, so we used the slide handouts exclusively
- Participants were more outgoing than at focus groups
- Need to send the rest of the invitations to the clinic next week

Pre- and post-test scores:

- ADS 1: 6, 7
- ADS 2: 6, 9
- ADS 3: 8, 9

- ADS 4: 7, 9
- ADS 5: 9, 10
- ADS 6: 7, 9
- ADS 7: 6, 8

Assessment questions:

1. What topics were the most interesting to you?
    a. CFPC =7
    b. IUD =7
    c. Jadelle = 7
    d. General info about LARC =6
    e. Flip chart =5
2. This training was useful to my work as an Animateur de Santé.
    a. All participants either strongly agreed or agreed
3. Which information presented was new to you?
    a. CFPC = 9
    b. IUD =8
    c. Jadelle =8
    d. General info about LARC=7
    e. Flip chart=5
4. Percent satisfied/understood after training
    a. More than 85%=9
    b. 75% =2
5. Which section should take more time?
    a. CFPC =7
    b. IUD =1
    c. Jadelle =1
    d. General info about LARC =6
    e. Flip Chart = 2

Assessment comments and suggestions:

- CHW should get samples of IUDs and Jadelle to show couples in order to remove the fear of using them
- Actual flip chart is necessary during promotions
- Training should be renewable in order to be more competent with work
- Better to have the training be 2 days
- Refresher trainings to evaluate how practice will be followed

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Comprehensive Summary:
Both trainings went very well, without any major issues. Participants were involved and asked frequent questions, and we saw improvements in pre- and post-test scores across both groups. From the assessment, we also found that the majority of participants said they understood 85% or more of the information presented.

Many participants indicated that they needed more training, and said they would benefit more from a 2-day training as the 1 day training was very long. Most indicated that CFPC was new and they would have liked to spend more time on it, so that can be adjusted in future trainings. Similarly, several suggested that we hold refresher trainings because this information is new to them, and they feel it would help them better understand the material. Furthermore, they suggested someone from PSF come into the communities with them to monitor how they are doing.

One individual had an interesting suggestion that I feel is worth pointing out. They suggested we do a section of the training in which they can go through the actions of counseling couples with specific fertility goals. We did include a "case studies" section in the training, but this would be more interactive and would allow them to use the flip chart and get immediate feedback from us. This also addresses their need for further training and monitoring.

I have taken this into account and propose several **recommendations** for future trainings:

1. Split the training up into 2 days
2. Spend more time focusing on CFPC during the second day
3. Maintain communication with ADS to increase the sustainability of the partnership
    a. Refresher trainings
    b. M&E of CFPC in communities
4. Hold meetings with heads of ADS at PSF before additional AIM 3 trainings
    a. Explain invitation system to them beforehand

Overall, I think the trainings were very successful, and I look forward to seeing if invitations start showing up at clinics in the following weeks

Next Steps:

- Follow up with clinics this week to see how it is going
    - Have patients returned invitations?
    - Do they need any additional supplies or support?

1. Visit clinic to see if couples that were recruited through ADS are coming in
    - Talk with them to assess how CFPC went
2. Meet with ADS after 1st round of invitations is completed
    - Discuss lessons learned, strengths, challenges, myths, and future recommendations (see ADS Follow Up Meeting doc)
3. Establish plan for tracking returned invitations

IV. Post Pilot Questionnaire Results

ADS LARC Promotion: Kabuye & Butamwa One-on-One Questionnaire

Open-ended responses:

	Q1. How did you choose which client to give the LARC invitation?	# of ADS with response
KABUYE:	I chose women who participated in the mother's health gathering in my village.	1
	I visited each house within my catchment area to meet with the mother to teach her about LARC methods.	2
	I focused on women who had used short term contraceptive methods prior (injectables, OCP).	2
	I visited women who had many children and not spaced their births strategically.	1
	Women approached me who were interested in LARC methods after a group talk.	1
	I discussed LARC methods with the village during community work on the weekend.	1
	I visited couples and single women who are fertile and of child bearing age.	1
BUTAMWA:	I targeted women who had never used a family planning method before.	1
	I promoted LARC methods to women who would listen to me.	2
	I traveled to women's homes whom I know do not have the funds to care for their many children.	2
	I visited women who children and not spaced their births strategically.	1
	Women approached me who were interested in LARC methods.	1
	I visited each house within my catchment area to meet with the mother to teach her about LARC methods.	2
	I chose women who participated in the mother's health gathering in my village.	2
	Q9. What challenges did you encounter when distributing LARC invites?	
KABUYE:	Women had prior misconceptions of LARC methods.	2
	Couples religious beliefs do not allow them to use LARC methods.	1
	None	2
	Women forced ADS to accompany them to the health center.	1
	Women refused LARC because of side effects.	1

	The community believes that a health center nurse will not remove the LARC method when asked.	1
	Women did not show up to scheduled appointment with health center.	1
BUTAMWA:	Women had prior misconceptions of LARC methods.	4
	Women accept invitation but then do not go to the health center to receive LARC.	1
	Time consuming for the ADS due to living distances.	1
	Couples religious beliefs do not allow them to use LARC methods.	1
	No family planning nurses available at the health center to provide insertion of LARC.	2
	One partner was interested in receiving LARC method but the other partner refused.	1
	Women were reluctant to travel to health center because it would interrupt their daily job.	1
	Q11. What suggestions do you have for improving the ADS LARC promotion system?	
KABUYE:	The number of ADS chosen to promote LARC should be increased.	3
	ADS need additional refresher trainings to require further knowledge.	2
	The number of nurses at the health center should be increased for inserting LARC.	1
	Nurses need to provide good services to the women so they will go to the health center.	2
	ADS incentives should be increased.	3
BUTAMWA:	ADS need additional refresher trainings to require further knowledge.	3
	ADS incentives should be increased.	2
	ADS need additional demonstration 3-D tool to better explain to women.	3
	Nurses need to provide good services to the women so they will go to the health center.	1
	ADS should provide brochure to women after visit.	1
	Couples should receive incentive for getting a LARC method.	1

Closed-ended responses:

ADS CODE:	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**	**Q7**	**Q8**	**Q10**
KAY001	1	1	1, 2	2	2	1 (AUG 2014)	2	1
KAY002	2	1	1, 2	3	1 (2x)	1 (JAN 2015)	3	1
KAY003	1	2	2, 5	1	1 (2x)	1 (DEC 2014)	2	1
KAY004	1	2	1	4	1 (2x)	1 (AUG 2014)	2	2
KAY005	1	1	1,2	3	1 (2x)	1 (/month)	2	2
KAY006	1	1	1	1	1 (2x)	1 (OCT 2014)	2	1
KAY007	3	1	1,2	1	1 (2x)	1 (/month)	1	1
BUT001	1	1,2	1,2	3	1 (2x)	2	3	2
BUT002	1	1	1,5	2	1 (2x)	1 (/month)	2	1
BUT003	1	1	1,2	2	1 (2x)	1 (NOV 2014)	2	2
BUT004	1	1,2	1	4	1 (2x)	1 (JUL 2014)	2	3
BUT005	1	2	2	2	1 (2x)	1 (MAY 2014)	1	1
BUT006	1	2	2	2	1 (3x)	1 (/month)	2	2
BUT007	1	1,2	1,5	4	1 (2x)	1 (JUL 2014)	2	2

Q2. In general, who initiated the conversation on LARC?

You (ADS) (1)
Woman (2)
Man (3)
Couple (4)

Q3. Did you talk to the couple together or woman alone?

Couple together
Woman alone

Q4. In general, where was the location of the invitation given?

Couple home (1)
ADS home (2)
Health center (3)
Market (4)

Social gathering (5)
Other: _____ (6)

Q5. In general, how long did you spend with the client when discussing LARC methods and the invitation process?

1-15 minutes (1)
16-30 minutes (2)
31-45 minutes (3)
46 minutes-1 hour (4)
More than 1 hour (5)

Q6. Did you ever meet with a client more than one time?

Yes (1) If yes, how many times?
2 times
3 times
4 times
More than 5 times

No (2)

7. Did you give any group talks?

Yes (1) If yes, when? _____ (Month and Year)
where? _____
No (2)

8. How challenging was initiating a conversation with a client with no prior family planning method?

Not challenging (1)
Somewhat challenging (2)
Very challenging (3)

10. How difficult was it distributing LARC invitations?

Not difficult (1)
Somewhat difficult (2)
Very difficult (3)

Interpretation:

- 86% of ADS reported they generally initiated the conversation on LARC with the clients.
- 71% of ADS reported when promoting LARC methods, they spoke with the couple together.
- 49% of invitations were given at the couple's home, while 39% were given at the home of the ADS.
- 36% of ADS reported the LARC promotion meeting lasted about 16-30 minutes.
- 86% of ADS reported that they met with the client on two separate occasions before the client received the invitation.

- 93% of ADS held group talks when promoting LARC; 31% of the group talks were held monthly.
- 71% of ADS reported that initiating a conversation with a client whom had never used a family planning method was somewhat challenging.
- 50% of ADS indicated that distributing LARC invitations was not difficult.

V. Post-pilot Focus Group Results

Focus Group feedback: Kabuye and Butamwa

Lessons learned:

Successful stories-

- ADS noticed that most of the time the 1st visit to the couple's home was usually not successful, however, they were consistent and tried a 2nd visit and the couple was receptive and the woman received LARC from the health center. All in all, couples were normally reluctant during the 1st ADS visit, but were convinced the 2nd time.
- Some spouses were in disagreement of the use of LARC the first time ADS approached couple. After 2 visits from the ADS, it gave the couple time to discuss further with more information given from ADS, and by the 3rd visit the couple agreed to receive LARC.

Better speaking to the woman only or couple together?

- An idea given by an ADS that others agreed on advised that speaking to the couple is better so it is a full disclosure agreement between the spouses. Also, it is likely if ADS visits home and the husband is not present, the woman will automatically tell ADS to return when her husband is home.
- Another approach given was to approach the spouse whom is most interested in LARC so both of them can convince the other spouse better understand the benefits. Then, they will together make their final decision.

Strengths:

Strategy for promotion-

- If you suspect a couple to be reluctant due to religious beliefs, do not begin the conversation with LARC and family planning. Instead, start the conversation discussing religion and then slowly segue into FP & LARC.
- ADS begin conversation asking the couple about their use of time management. ADS reinforces that LARC needs no time management or upkeep. [Example: ADS approached woman whom was using a short-term method. She was complaining about the amount of times she was forced to visit the ADS home for her chosen short term method and how it was hindering her job. ADS began to promote LARC for benefits and better time management.]
- ADS advise to begin the discussion by asking the mothers their prior knowledge on LARC. Normally, it will be very low if any at all.

Most important key points to empathize-

- Promoting that LARC works for long periods of time. This gives the woman more time with herself and her whole family.
    - Also encourages time management
- Promoting more IUD which is non-hormonal than Jadelle which has more side effects.
- ADS gives personal & positive experience when using LARC method. Also, emphasizing if woman experiences side effects, ADS and health center staff are available to help alleviate those side effects or change methods.
- Benefits of LARC versus upkeep of short term methods (injectables, OCP).

Challenges:

1st impressions of woman with no prior FP knowledge:

- Not challenging speaking to couples who had never had LARC. The challenging issue ADS faced was approaching strangers (newcomers in the village) in their community and beginning such a personal conversation like LARC. Families are not accustomed to being visited by ADS at their homes.
- Couples suggest that ADS are only promoting LARC because of an incentive the ADS will receive. [ADS response is they are following Ministry of Health instruction because of solid LARC benefits.]
- Couples challenge ADS by saying that their mothers/ancestors did not use a modern FP method and they had healthy families.
- Couples question the validity of injectables and OCP now that ADS are promoting LARC. [Could a new method far outweigh LARC in the long run?]

Myths encountered:

No new myths other than ones previously discussed during ADS training.

Level of knowledge of ADS before LARC promotion-

- Many ADS indicated they had very few facts on LARC, and those that did had false information.
- Most clients that received LARC had never been on it prior.

Future Recommendations:

Advice to future ADS-

- Have courage & never give up. ADS' need to be consistent in their home visits and have patience when the couples are skeptical.
- Never promote something that you are not knowledgeable about; make sure you are well-informed. A couple will be less likely to receive LARC if you do not know an answer to their question.
- Knowing the client before talking about LARC is beneficial, but promoting to strangers (newcomers) is possible if done the appropriate way.

ADS recommendations for future trainings:

- No specific recommendation for training module.
- Increase incentive, 500 rwf is not enough especially since ADS are visiting couples homes sometimes up to 3 times and the distance hinders their evenings.
- Refresher training regularly to update knowledge
- Give transport money to clients to health center for motivation.
- Increasing staff at clinic.
- Add more ADS representatives for each clinic. (More than 7/clinic)

PSF future suggestions for ADS Promotion:

- Increase incentive from 500 rwf to 1,000rwf since ADS are visiting couples homes up to 3 times for 1 client.
- Keep training content as is, however, change training from 1 day to 2 days.

    - CFPC role plays/skits on how to approach clients with different myths/impressions of LARC for better understanding. Promotional conversations will differ depending on the client. [Day 1 would focus on didactic understanding of LARC, day 2 of training would focus on applying skills learned with scenarios.]
- Increase ADS representatives per clinic. We chose 7 ADS each for Kabuye and Butamwa for the pilot study, but for the future LARC trainings we would like to train ADS for EACH village that corresponds with the particular health center. This would create a knowledgeable family planning ADS in every village of the area in LARC methods, and increase the number of women that receive LARC in villages that do not have a current ADS promoting LARC. On average, each clinic can be up to 22 villages/ADS. Since we would be increasing the number of ADS trained, we would only give 5 invitations for each ADS, which would still increase the number of invitations overall.
- Develop a leaflet/brochure of key information to standardize the LARC message for ADS to give to clients at home visits.