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Maternal and Child Survival Program

Implementing and Maintaining High-Quality LARC Service:

A Guide for Using the LARC Learning Resource Package

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MCSP is a global USAID initiative to introduce and support high-impact health interventions in 25 priority countries to help prevent child and maternal deaths. MCSP supports programming in maternal, newborn, and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment. MCSP will tackle these issues through approaches that also focus on household and community mobilization, gender integration, and digital health, among others.

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Abbreviations

ANC	Antenatal Care
FP	Family Planning
HMIS	Health Management Information System
IUD	Intrauterine Device
LARC	Long-Acting Reversible Contraceptive
LRP	Learning Resource Package
LNG-IUS	Levonorgestrel Intrauterine System
MCSP	Maternal and Child Survival Program
MOH	Ministry of Health
PAC	Postabortion Care
PNC	Postnatal Care
PPC	Peer Practice Coordinator
PPFP	Postpartum Family Planning
PPIUD	Postpartum IUD
QI	Quality Improvement
WHO	World Health Organization

Acknowledgments for LARC Learning Resource Package and Implementation Guide

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Introduction

Purpose

This implementation guide is part of the Long-Acting Reversible Contraceptives Learning Resource Package[1] (LARC LRP). The purpose of the LARC LRP is to provide trainers, facilitators, and program staff with a comprehensive resource for high-quality LARC services using a modular, facility-based approach for training, capacity-building, and mentorship.

Audience

The LARC LRP Implementation Guide is written for a global audience and designed to be used by personnel responsible and/or involved in any of the phases of implementation of LARC services.

How to Use

This implementation guide is designed to be used in conjunction with the 10 LARC LRP modules. It introduces and familiarizes LARC facilitators and program managers to the training approach and contents of the LARC LRP modules and explains how to conduct LARC trainings effectively. It is recommended that the LARC facilitators familiarize themselves with this guide before implementing LARC training using the LARC LRP.

The implementation cycle outlined in this document can be adapted to meet the needs of countries that are introducing, implementing, or expanding LARC services.

LARC LRP Content

The LARC LRP consists of 10 modules that provide facilitators and learners with consolidated, essential information about the safe use of LARCs, specifically intrauterine devices (hormonal and nonhormonal), and contraceptive implants (single and two-rod) in the pre-pregnancy, postabortion, and postpartum periods. Table 1 lists the titles of the course modules.

Table 1. LARC LRP Modules

Module	Duration
Module 1: Introduction to Long-Acting Reversible Contraceptives	5 hr. 40 min
Module 2: Family Planning Counseling	8 hr. 10 min
Module 3: Medical Eligibility and Client Assessment	4 hr. 50 min
Module 4: Quality of Care	6 hr.
Module 5: Infection Prevention for LARC Methods	9 hr.
Module 6: Copper Intrauterine Device (Copper T 380A)	10 hr.
Module 7: Hormonal Intrauterine Device (LNG-IUS)	10 hr. 15 min
Module 8: Postpartum Intrauterine Device	10 hr. 20 min
Module 9: Postabortion Intrauterine Device	8 hr. 30 min
Module 10: Contraceptive Implants	10 hr. 55 min

[1] Maternal and Child Survival Program (MCSP). 2017. *Long-Acting Reversible Contraceptives Learning Package*. Washington, DC: MCSP. https://www.mcsprogram.org/resource/providing-long-acting-reversible-contraception-larc-learning-resource-package/

The LARC LRP is interactive and designed for individual or group-based training with special attention given throughout to learning and practicing skills through role plays, simulations (i.e., with anatomical models) and with family planning clients. Each module has a facilitator and learner version. The facilitator version includes a comprehensive overview that walks the facilitator through the module objectives, materials and supplies, and detailed session plans, including a sample schedule. The learner version of each module contains informational handouts, job aids, and checklists related to a particular skill. These tools can be used while learning, during practice with models, or in clinical settings. (Please refer to the section *How to Use the LARC LRP* for a more detailed explanation of module content.)

When using this guide and the corresponding LARC LRP modules, it is important to ensure that appropriate adaptations are made to ensure they fit local laws, policies, available resources, and contexts.

The LARC LRP content is based on evidence for effective in-service training and key resources such as the: Family Planning Training Resource Package, Family Planning: A Global Handbook for Providers, and Jhpiego and partner training materials.

Learning Approach

The LARC LRP was developed by applying the latest evidence of methodology and practices to ensure training translates into performance. **This evidence suggests that learning within the workplace, in short segments with frequent practice and a focus on doing, rather than knowing, is the most effective at impacting performance**. Traditional training approaches that use extended, off-site, group-based workshops have had limited effectiveness in improving and maintaining provider performance after training. New evidence identifies better ways to sustain improvements in service delivery. Reflecting Jhpiego's Learning & Performance strategy, the LARC LRP:

1. Situates performance-based, context-specific, and case-based capacity-building interventions within a broader continuous quality improvement cycle.
2. Promotes shorter, repeated, team-oriented, workplace-based (sometimes called "low-dose, high-frequency" or LDHF) learning activities.
3. Stresses the importance of ongoing learning reinforcement to build a culture of quality. This may come in the form of prescribed practice, digital health supports such as text messages, and structured mentorship or coaching.
4. Aims to link learning interventions with impact and outcome (rather than output) measures.

Principles of Low-Dose, High-Frequency Training

1. Competency-focused learning activities
2. Simulation- and case-based learning
3. Appropriately spaced, brief periods of learning
4. Facility-based delivery and team-focused training
5. Ongoing practice of skills
6. Facility-based peer staff schedule and coach
7. Quality improvement efforts
8. Tracking results

The LARC LRP follows the principles of the Jhpiego-pioneered LDHF training approach[2] (see text box). The following paragraphs explain how these principles are reflected in the LARC LRP.

Competency-focused learning activities concentrate on what providers "need to know"—eliminating what is "nice to know." Presented in a modular fashion, it can be tailored to the needs of a facility.

Simulation- and case-based learning focuses on skills practice, problem-solving, role play, and other interactive exercises.

[2] Jhpiego. 2016. *Low Dose, High Frequency: A Learning Approach to Improve Health Workforce Competence, Confidence, and Performance*. Baltimore: Jhpiego. https://hms.jhpiego.org/wp-content/uploads/2016/08/LDHF_briefer.pdf.

Appropriately spaced, brief periods of learning deliver targeted information over several days. Dosing and frequency depend on the topic, the extent of the learning gap, and learner characteristics. Modules comprise several sessions depending on the overall length of the topic, with each session lasting no more than 3 hours.

Facility-based delivery decreases absenteeism, improves teamwork, addresses on-site barriers, and promotes changes to provider performance. It can be used to support both facility-based training (where providers come from their job sites to another site for initial training) and on-the-job training (where providers are trained at the facility where they work).

Team-focused training ensures that the entire team is trained so that all providers will be onboard with the new or updated clinical practice and can work together to implement improvements.

Structured, facilitated **ongoing practice of skills** follows training to reinforce learning and support transfer to clinical practice.

Using **facility-based peer staff** to schedule and coach others as they practice or engage in interactive exercises increases compliance and improves performance and outcomes.

However, change in clinical performance requires more than initial training and ongoing clinical skills practice sessions. The service delivery system also needs to be examined, with gaps noted and addressed. **Quality improvement efforts** should guide the selection and delivery of content areas.

It is important to assess clinical performance and outcomes, where feasible. **Tracking results** can be done through observation of the procedure at a skill station prior to the beginning of the training, and as a follow-up assessment. Clinical outcome data should be used to help document the effectiveness of the approach and to note any gaps in performance.

The LARC LRP uses a method of instruction called mastery learning, which assumes that ***all* learners can become competent, given sufficient time and opportunity to study and practice**. For each module they complete, learners are required to demonstrate mastery of the module objectives in simulation and in a clinical setting before they are certified.

Implementation of the LARC LRP

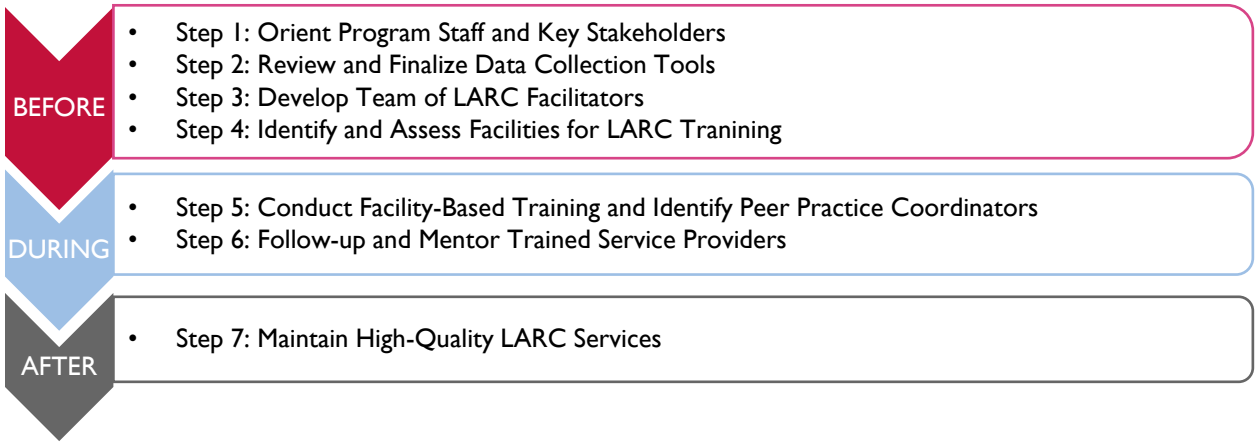
Overview

In sum, the LARC LRP uses an **on-site modular learning approach** that helps build and strengthen the competency and confidence of providers to learn and perform essential job skills with minimal disruption to services. Training should be tailored to be used on an as-needed basis, in a facility and include mentoring to provide side-by-side teaching. (Please see the *MCSP Global Mentoring Program Brief* for more details on mentors.[3])

Implementation Steps

Implementation activities for using the LARC LRP can be broken into seven steps. These steps are organized into three phases as illustrated in Figure 1.

Figure 1. Seven-step implementation process



The *Before* phase includes the preparatory activities that need to be completed before starting the facility-based training. In the *During* phase the LARC LRP modules are implemented in facilities and the *After* phase assures sustainability of quality LARC services after learners achieve clinical competence. (Please note, that in order to fit local context, these steps may not happen in the exact order they are listed.)

To be successful, communication and coordination with governmental authorities, the health facilities, and the learners are essential throughout the seven-step process.

BEFORE

Step 1: Orient Program Staff and Key Stakeholders

- Orient program staff to the on-site modular learning approach and familiarize them with the LARC LRP content.
- Schedule a meeting with key stakeholders, such as the Ministry of Health (MOH), to advocate for implementation of on-site modular LARC trainings and orient them to the learning approach in the LARC LRP.

[3] MCSP. 2017. *MCSP Global Mentoring Program Brief*. Washington, DC: MCSP. https://www.mcsprogram.org/resource/mcsp-global-mentoring-program-brief/

- Emphasize the flexibility of the approach (e.g., the ability to conduct needs-based trainings at the facility at times that are acceptable to the learners and do not disrupt services).
- Share copies of the LARC LRP modules and implementation guide and present the key features of these materials.
- Share experiences and successes from other programs and countries that have used this approach.
- Discuss the feasibility of implementing this approach with key stakeholders to get their buy-in.
- Request that the MOH or other key stakeholders identify health care providers who are providing family planning services and can be trained as LARC facilitators.
- In coordination with the MOH or other key stakeholders, draft an implementation plan that includes who will conduct the trainings and where, when, and how they will be conducted.
    - Ensure the availability of funds, supplies, and human resources, etc.
    - Ensure that the plan includes the identification and training of LARC facilitators, site assessments, the content of facility-based training, and follow-up support for service providers.

Step 2: Review and Finalize Data Collection Tools

- Review the existing system and tools for monitoring family planning services (e.g., the family planning register and monthly reports).
- Meet with the MOH, including the division that oversees the national health management information system (HMIS), to discuss which tools need to be modified to record and monitor LARC services.
    - Adapt existing tools:
        - Any new family planning method(s) should be added to existing tools in order to record the number of clients receiving the method(s).
        - If postpartum family planning services are a focus, recording the number of postpartum women receiving family planning is also important.
        - Tools may also be modified (or introduced) to record the number of clients counseled, follow-up visits conducted, complications, and removals.
- For examples from countries that have adapted tools to collect data on family planning received soon after birth, see *Appendix A: MCSP Monitoring PPFP Brief.*
- In some cases, a new tool may be necessary, though it is preferable to incorporate data into existing tools whenever possible to avoid duplication of data collection, minimize the burden on providers, and minimize printing costs.
- It is important to think about tools that facilitate review of data at facility, district, and national levels.
    - For example, wall charts or dashboards to visualize trends in LARC uptake should be added into existing visualization tools, if not already included.
- Work with the MOH to plan for testing modified or new tools.
    - Ideally, modified or new tools should be introduced to providers during LARC training and tested soon after.

- Be aware that modifying the HMIS can take time, and strong evidence is often necessary to make changes at the national level.
- During the testing phase, put in place systems for collecting, analyzing, and reviewing data that are not yet in the HMIS but are necessary to monitor LARC services. These data will need to be aggregated and analyzed separately.

- Tailor Module 4 of the LARC LRP (Quality of Care, which contains sessions on data use) to fit the monitoring tools and data reporting system that will be used.

Step 3: Develop a Team of LARC Facilitators

- See the section Learning Cycle for details of each actor's roles and qualifications.
- In consultation with the MOH and other key stakeholders, schedule a training to develop the capacity of identified health care providers to serve as LARC facilitators.
- Arrange for an advanced trainer and local trainers/experts to facilitate the training.
  - Meet in advance to familiarize the trainers with the LARC LRP modules.
  - Discuss the sample agendas and make changes to fit local context.
- Make arrangements for the LARC facilitators' training:
  - Print materials for both learners and facilitators.
    - See the section *How to Use the LARC LRP* for more details on printing materials.
  - Secure samples of contraceptives and other supplies.
    - See the Materials and Supplies table in the Module Overview for Facilitator of each module.
  - Identify and prepare clinical training sites for clinical practice sessions.
    - Coordinate with the facility the best dates and times for clinical practice.
    - Ensure that demand creation activities take place at the facility prior to the training to ensure sufficient client load for clinical practice.
  - Arrange all other logistics such as meals, lodging, and transportation as needed.
- During the training:
  - Orient the participants to the training approach, including required facilitation skills, and discuss different ways to implement it.
  - Familiarize the participants with the LARC training modules.
  - Update the participants' knowledge and skills regarding LARC methods.
  - Ensure participants' competency in clinical skills before certifying them as LARC facilitators.
    - Please see *Appendix B: Learner Assessment* for more details.

Step 4: Identify and Assess Facilities for LARC Training

- Identify high-volume facilities (or facility) to host a LARC training.
    - It is recommend to choose sites with a high volume of clients for labor & delivery and family planning services to ensure enough clients are available during clinical practice and certification.
- Learners from smaller facilities can come to a high-volume site for training. Meet with the staff in charge of the facilities and orient them to the activity.
- Conduct a facility readiness assessment in selected facilities using Appendix C: Facility Readiness Assessment Tool or other LARC assessment tools available in-country.
    - A readiness assessment should include a review of human resources, equipment and supplies, management systems, as well as existing data collection and review systems used at the facility.
- Identify root causes of the gaps observed, which largely can be categorized as:
    - Lack of adequate competencies, which requires on-site learning activities.
    - Lack of equipment/materials/supplies/drugs and support systems, which requires implementation of management improvement activities.
    - Lack of motivation, including inadequate team working climate and internal conflicts, which requires activities to improve the team working climate and address/prevent conflicts, and finding ways to re-energize and motivate the staff.
- Share the needs assessment results with key stakeholders, including the MOH and staff in charge of the facilities, highlighting any major gaps in provision of LARC services (e.g., staff shortage, FP supplies, etc.).
- Information from the facility readiness assessment will be used to plan trainings and follow-up under Steps 5 and 6.

DURING

Step 5: Conduct Facility-Based Trainings and Identify Peer Practice Coordinators

- Coordinate and plan facility-based trainings with the MOH/key stakeholders and program staff.
- Use Appendix D: Training Preparation Checklist to support advance preparation and same-day planning for the training.

Before:

- Orient the facility managers and other key personnel to the training approach and plan the training schedule.
- Request staff support in identifying providers who will be learners for the training.
    - Emphasize that the training will be done during hours that are convenient and will not disrupt routine services.
- Using information obtained in Step 4 (facility needs assessment) customize training to match the needs of each site.

- Identify a quiet training space with adequate light and ventilation for classroom and skills sessions.
- If client load at the facility is insufficient to allow learners to perform clinical practice during training, partner with a facility that has a larger client load.
- Ensure that supplies, instruments, and teaching aids are available, as detailed in each *Module Overview for Facilitator*.
    - Prepare learner material folders and supplies in advance.
- Visit the facility 1–2 days before the training date to ensure that learners have been informed and space is ready for the training.
    - Check that all supplies and equipment needed for skills practice sessions are in place.

During:

- Use the *Module Overview for Facilitator* found in each module for guidance on each topic area.
- Ensure patient safety by orienting all learners to severe adverse event reporting using national or other appropriate severe adverse event guidelines and reporting forms.
- Identify high-performing learners to serve as peer practice coordinators (PPCs) and mentor them in their role to support other learners in the facility.
    - See the *MCSP Global Mentoring Program Brief*[4] for more details on mentoring.
    - See sections *Key Actors* and *Roles and Responsibilities by Actor* for details of each actor's roles and qualifications.
- Identify learners who need additional support and link them to the PPC for additional and continued support.
    - Please see *Appendix B: Learner Assessment* for more details.
- In collaboration with the PPCs, prepare plans for follow-up and mentoring for identified learners who need more practice (use *Appendix E: Learner Mentoring Plan).*
- Complete *Appendix F: Participant Tracking Matrix,* to record the details of the trainings.

After:

- Using *Appendix F: Participant Tracking Matrix,* map the performance level for participants for each module. This will help as a record to identify participants who need additional support in any of the modules.
- Prepare a brief training report and share it with concerned staff and key stakeholders, including the MOH.
    - An updated version of this report may also be submitted under Step 6 once additional learners have reached competency.

[4] MCSP. 2017. *MCSP Global Mentoring Program Brief*. Washington, DC: MCSP.

Step 6: Follow-up and Mentor-Trained Service Providers

- LARC facilitators should provide regular on-the-job mentoring and supervisory visits to the facility to ensure confidence and competence of the newly trained LARC providers.
    - If possible, visits should take place every 15 days for the first 3 months post-training, then monthly for the next 6 months. However, frequency will depend on learner performance.
    - Mentoring of learners should include side-by-side teaching and providing feedback on performance — what went well and what needs improvement.
    - Coordinate with the PPCs to monitor progress and provide additional support to learners who need more practice.
    - Document on-the-job coaching by the PPCs and keep the *Participant Tracking Matrix* and *Learner Mentoring Plan* up-to-date (see *Appendices E and F*).
    - Ensure that all learners qualify in the clinical skills assessment within 6 weeks of attending the LARC training course.
- PPCs should help trained service providers to meet their learning goals. This includes:
    - Side-by-side teaching using models, checklists, and job aids.
    - Working in close coordination with LARC facilitators to keep a record of each participant who was supported after the clinical training.
    - Requesting further technical support, if required, from LARC facilitators.
    - Inviting a clinical mentor to certify a participant for a new clinical skill.
- During supervisory visits, LARC facilitators should also review data for LARC services, which should include the number of clients receiving each type of LARC.
    - Depending on what data are routinely collected (see Step 2), in addition to number of clients accepting a method, the review may also include the number of clients counseled, receiving follow-up visits, experiencing complications, or coming for removal.
    - Data may come from aggregated reporting forms or visualization tools such as wall charts or dashboards.
    - This review may also look at characteristics of clients receiving services, such as age or parity.
        - Such profile characteristics, and other data, may not be aggregated or reported, and therefore may require looking at registers to get the information.
- Once certification of learners is complete, LARC facilitators should prepare an updated training report and share it with concerned staff and key stakeholders, such as the MOH.
        - For detailed information on the assessment of learners, please see *Appendix B: Learner Assessment*

AFTER

Step 7: Maintain High-Quality LARC Services

- Follow-up, supportive supervision, and mentoring by the facilitators and MOH staff during visits are key to maintaining high-quality LARC services. During these visits, it is important to:
  - Ensure that the trained facility staff are providing high-quality LARC services.
    - This can be verified through observations and discussions to ensure service providers continue to follow standard guidelines/protocols when providing LARC services.
    - Additional supportive supervision, mentorship, or refresher training should be planned for as needed based on findings from these follow-up visits.
  - Confirm that trained staff at the facilities document service delivery data for LARC services.
  - Continue to review available data (see Step 6).
    - Use supervision visits to learn if facilities regularly review data to assess the use and quality of LARC services. Encourage the use of data to track improvements and identify problems.
    - If data suggest problems at the facility, decide on the appropriate action to take: retraining, refresher training, on-the-job training, etc.

Learning Cycle

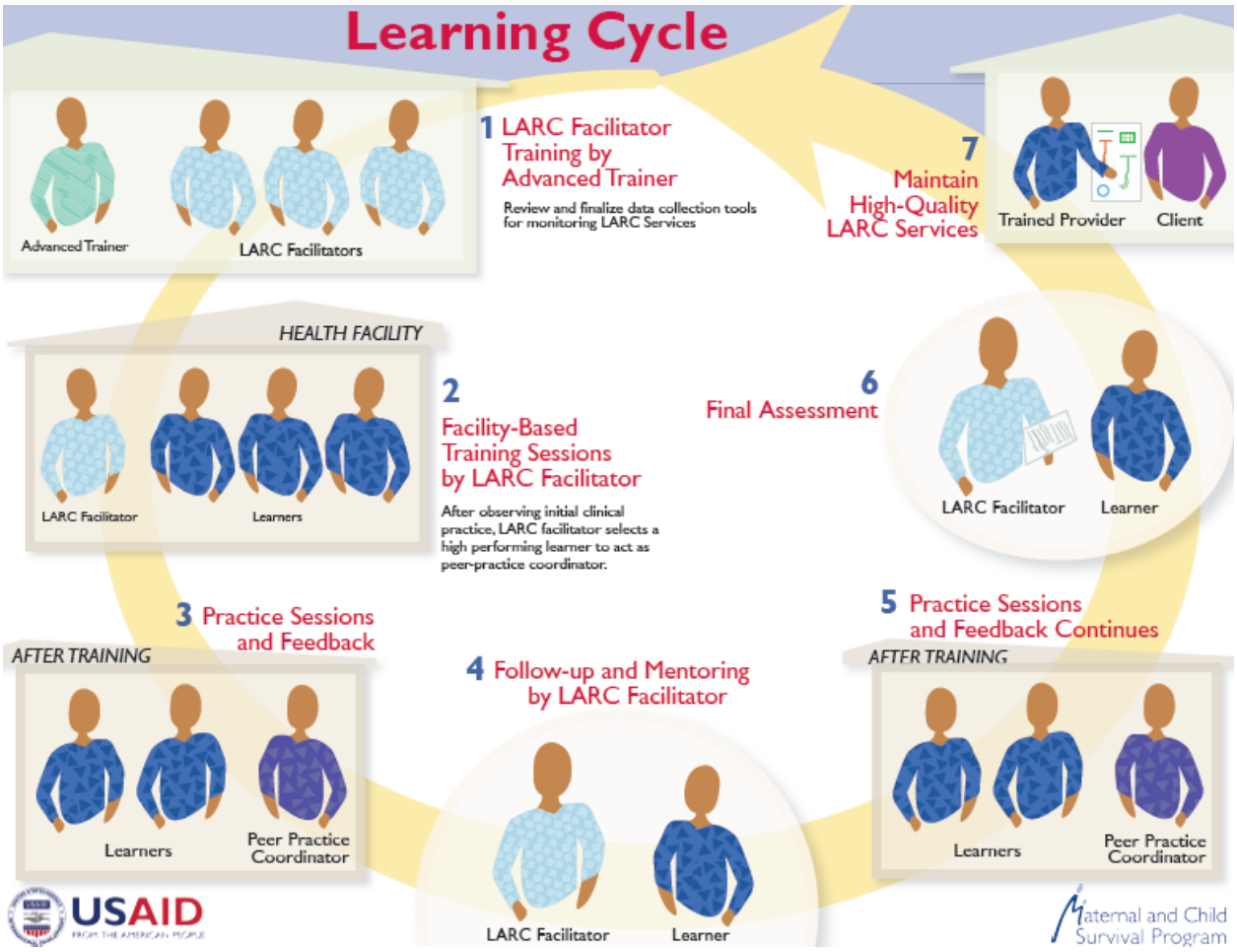
Steps 5–7 of the Implementation Process focus on the learning cycle. The learning cycle illustrates how (as described in the Learning Approach section) all content delivery should be followed by reinforcement through consistent, scheduled practice over a sufficient period of time, using LARC facilitators and PPCs. Clinical mentoring is a vital step to ensure implementation of high-quality LARC services.

The learning cycle outlined in this package begins by developing a team of LARC facilitators and then supporting them to use the LARC LRP modules to train facility-based learners in short updates of selected content. The LARC facilitators implement training modules based on learning priorities at each site, and they take participants through the learning cycle.

Once the content is delivered, it is key to build on the short training sessions with immediate practice and feedback. Through this process, learners receive additional follow-up and mentoring over time to integrate new knowledge and skills during clinical practice and to prepare them for final assessment by a clinical mentor.

Please see Figure 2 for a visual overview of the learning cycle.

Figure 2. Learning cycle



Key Actors

Four key groups of "actors" are involved in implementing the LARC LRP. Although titles may differ in each country, roles and qualifications do not. See Table 2 below for the general actors and their roles and qualifications.

Table 2. Actors, roles, and qualifications for implementing the LARC LRP

	Advanced trainer	LARC facilitator	Peer practice coordinator (PPC)	Learner
Role	Designs and provides technical guidance Trains and orients LARC facilitators Assists in developing monitoring and mentoring	Conducts a training needs assessment and trains learners Identifies, trains, and mentors PPCs Follows up and mentors learners Conducts performance assessment of learners	Schedules practice sessions with peer learners Coaches peer learners during practice sessions and records results on mentoring plans Records practice sessions Coordinates with LARC facilitators to share progress of peer learners	Completes the LARC LRP modules as needed Takes responsibility and ownership for own practice and learning and aspires to provide high-quality services
Qualifications	Family planning provider proficient in LARCs and trained as a LARC facilitator	Family planning provider proficient in LARCs and trained as a LARC facilitator	High-performing LARC provider willing to support peer learners Respected by peer learners	Family planning, postabortion, antenatal, or maternity care provider working in health facility (doctor, nurse, midwife)

Roles and Responsibilities by Actor

Advanced trainers are senior technical staff who are proficient in providing LARC services and have previous experience in designing/adapting training courses to fit local context. This team of advanced trainers will work in close coordination with key stakeholders (such as the MOH), and will:

- Provide long-term support to national, regional, and district technical teams for high-quality LARC services.
- Organize and facilitate a training to develop a pool of LARC facilitators for each region.
- Work with the HMIS division in the MOH to decide how to modify tools to capture and monitor LARC services. (They will adapt Module 4 of the training manual to reflect these decisions.)

LARC facilitators play a key role in providing on-site training, mentoring, and support to providers at facilities. They help ensure that facility providers continue to practice and sustain their new skills. They should be:

- Experienced midwives, obstetricians, or regional/district trainers providing family planning services/training.
- Trained in clinical mentoring methodologies and skills.
- Experienced in conducting follow-up and/or mentoring visits for service providers at the facility level.
- Experienced in using existing facility registers and able to review data to monitor LARC services.

- Willing to work as a team member and accept the role of LARC facilitator (traveling, supervising, and collecting data as part of the team) for at least 2–3 years.
- Flexible regarding selection of training space and shifting schedules to accommodate service provider availability.
- Willing to coordinate with the district/regional teams to implement the trainings, participate in joint planning, and provide mentoring support to participants at national, regional, and facility levels.
- Have strong linkages with quality improvement (QI) teams (if these teams exist) and work with them to close gaps and improve the quality of LARC services.

There should be one LARC facilitator for every six learners to be trained in any given facility.
Before a facility-based training begins, LARC facilitators should:

- Have been assessed and certified as competent in providing LARC services.
- Be familiar with all components of the LARC LRP materials and training approach.
- Assess the facility where trainings will be implemented (see Step 4 of the *Implementation Process*).
- Meet with the facility in-charge to plan the training and visit the facility again 1–2 days before training to ensure that the participants and space are ready (see *Before* section in Step 5 of the *Implementation Process*).
- Review the session plans for each module that will be implemented, revising as needed to fit the local context, and if there are multiple facilitators, divide tasks and responsibilities accordingly.

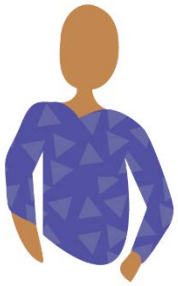
During implementation of facility-based training, LARC facilitators should:

- Implement facility-based training sessions using the materials provided in the LARC LRP modules.
- Confirm that a sufficient number of clients are available on clinical practice day.
- Identify PPCs and learners who need additional support and prepare plans for follow-up and mentoring (see *During* section in Step 5 of the *Implementation Process*).

After implementation of facility-based training, LARC facilitators should:

- Support regular on-the-job mentoring and follow-up visits to the facility (see Step 6 of the *Implementation Process*).
- Work in close coordination with the PPCs to monitor progress and provide any additional support needed.
- Schedule and conduct refresher training sessions if needed.
- Coordinate with QI teams to monitor the quality of services as well as data collection and use at the facility (where QI teams exist).

Peer Practice Coordinators (PPCs) are high-performing learners who are selected from among the facility- based learners by the LARC facilitators and are given the responsibility of coordinating practice with their peers. It is important that the chosen PPCs be respected, well liked, and acceptable to the group of learners. A ratio of one PPC to two learners is ideal.



PPCs should have passed the knowledge and skills assessment for any given module. In instances where this is not feasible, the LARC facilitator agrees on what skills PPCs can provide support to their peers and what skills need to be deferred until the LARC facilitator or advanced trainer is present.

PPCs should:

- In collaboration with the LARC facilitator, make a plan for conducting clinical practice sessions for their peers and support and document the planned practice and feedback sessions (see Step 6 of the *Implementation Process*).
- Request further technical support, if required, from LARC facilitator.
- Invite a clinical mentor to certify a participant for a new clinical skill.
- Inform the LARC facilitator and facility in case of a serious adverse event.

How to Use the LARC LRP Materials

Overview

The LARC LRP comprises 10 modules (see Tables 1 and 3). Modules 1–5 are cross-cutting and support all LARC services, while modules 6–10 cover clinical skills for the LARC methods.

With the modular design, it is not necessary to implement all 10 modules. Rather, teams can use the assessment tools to choose the modules that are most appropriate for a facility or team of providers. However, at least a refresher on modules 1–5 should be carried out before moving to any of the clinical skill modules.

Modules 4 and 5, Quality of Care and Infection Prevention for LARC Methods, should be implemented with a broader audience. This includes, but is not limited to, managers, doctors, nurses, midwives, pharmacists, laboratory technicians, and support personnel (including cleaning and waste management staff).

Counseling is often the weakest component of family planning service provision. ***Module 2: Family Planning Counseling*** **should be implemented during every LARC training, and counseling should be reinforced during each skills module.** All personnel who provide family planning services should take part in the counseling module. This includes physicians, nurses, midwives, and community health workers.

Table 3 lists the modules and their approximate duration.

Table 3. Course modules and duration

Module	Duration
Module 1: Introduction to Long-Acting Reversible Contraceptives	5 hr. 40 min
Module 2: Family Planning Counseling	8 hr. 10 min
Module 3: Medical Eligibility and Client Assessment	4 hr. 50 min
Module 4: Quality of Care	6 hr.
Module 5: Infection Prevention for LARC Methods	9 hr.
Module 6: Copper Intrauterine Device (Copper T 380A)	10 hr.
Module 7: Hormonal Intrauterine Device (LNG-IUS)	10 hr. 15 min
Module 8: Postpartum Intrauterine Device	10 hr. 20 min
Module 9: Postabortion Intrauterine Device	8 hr. 30 min
Module 10: Contraceptive Implants	10 hr. 55 min

The LARC LRP modules are designed to be delivered in one of two ways:

- **On-the-job**: Implemented in high-volume sites where learners are all from the same facility.
- **Facility-based:** Implemented for learners from small facilities who come to a high-volume site for training.

Each module is broken down into sessions, and **no session is longer than 3 hours**. It is recommended that the modules be implemented with:

- A maximum of 3 hours per day for didactic, model, and clinical practice.
- A maximum of six participants for each clinical skills training module.

Sample Training Scenarios

Table 4 describes potential training scenarios for three types of learners. These examples may help you consider your situation:

Table 4. Training scenarios for three types of learners

Scenario 1	Scenario 2	Scenario 3
Learners: New providers who have no clinical skills for inserting or removing implants and/or IUDs	**Learners**: Providers who need one or more clinical skill(s) • E.g., Implanon insertion and removal	**Learners**: Providers who need one or more clinical skill(s) and have recently completed training in all 5 cross-cutting modules • E.g., postpartum IUD insertion
Training Need: All 10 modules	**Training Need:** All 5 cross-cutting modules, plus the clinical skill module(s) needed • E.g., modules 1–5 and Module 10 for implant insertion and removal	**Training Need:** Specific clinical skill module(s) • E.g., Module 8 for postpartum IUD insertion
Estimated Duration: 30 working days (consecutive or non-consecutive) with a maximum of 3 hours per day of didactic, model, and clinical practice.	**Estimated Duration:** • 2-3 working days for each cross-cutting module • 4 working days for each clinical skill module	**Estimated Duration:** 4 working days for each clinical skill module

What is in Each Module

Each module is a standalone unit with all the materials for the facilitators and learners: a module overview, pre-/post-tests, activities, checklists, handouts, job aids and facilitator tools, as well as a list of materials and supplies needed for that module. Some of the job aids and checklists are needed for several modules (e.g., the *World Health Organization (WHO) Medical Eligibility Criteria (MEC) Quick Reference Chart*[5]).

The sample schedules included in each module are simply examples. The actual timing for each session, as well as the materials used in each module, will need to be adjusted to fit the local situation.

Modules are in PDF format and there are two versions of each module, one for the facilitator and one for the learner. Facilitators should have an electronic and a hard copy of all the resource materials because in addition to print material, as some of the modules also contain videos and slide presentations.

The *Module Overview for Facilitator* is the key document in each module that guides the facilitators through the content, outlines the module objectives, and includes detailed session plans and a sample schedule. This document helps facilitators familiarize themselves in advance with the module content, timing, resources, and methodology, and it is also used to plan training sessions.

[5] FHI 360. 2016. *Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use*. Durham, North Carolina: FHI 360.

Page 2 of each Module Overview for Facilitator has a *Materials and Supplies Table* that lists the documents included in both the learner and the facilitator version of each module (see Figure 3). Before the start of training, facilitators should review the list of required supplies (located at the end of the Materials and Supplies table) in order to ensure that the supplies are available for each session (e.g., markers, flip charts, and contraceptive samples).

Materials and Supplies

Figure 3. Partial Materials and Supplies table from Module 2

Category	Name	Items to Print For	
		Facilitator	Learner
Assessments	Pre-/Post-Test Questionnaire		X
	Pre-/Post- Test Questionnaire Answer Sheet		X
	Pre-/Post-Test Questionnaire Answer Key	X	
Activities	Activity 2-1: Reflection Exercise	X	
	Activity 2-2: Instructions: Lily's Story	X	
	Activity 2-3: Lily's Story	X	
	Activity 2-4: Diverse Counseling Group Scenarios	X	
	Activity 2-5: Role Play Scenarios	X	

The *Session Plans* walk the facilitator through the topic for each session, the objectives, the teaching methods and activities, and the materials/resources needed (see Figure 4). Session plans should be reviewed before the start of training.

Session Plans

Module 2—Session 1

Figure 4. Partial Session Plan from Module 2

Date	Venue	Session number: 1	Duration: 175 min
Topic: Counseling: Interpersonal Communication Skills and Gender-Related Issues			
Session Objectives: By the end of the session, learners will be able to: • Name at least three essentials of effective interpersonal communication skills • Identify at least two gender-related issues that influence family planning counseling, uptake and use • Address the key barriers to LARC uptake among the youth			

Methods and Activities	Materials/Resources
Introduction (5 min) • Review session objectives with learners	• Objectives on Flip Chart
Pre Test (10 min) • Distribute copies of the Pre Test questionnaire and instruct learners about how to take the test • Collect the answer sheets	• Pre-/Post-Test Questionnaire and Answer Sheet (for learners) • Pre-/Post-Test Questionnaire Answer Key (for the facilitator)
Reflection Exercise (15 min) • Follow the instructions in Activity 2-1: Reflection Exercise to facilitate this activity	• Activity 2-1: Reflection Exercise

Printing

Print as many copies of each module as needed, keeping in mind that:

- When training LARC facilitators, print both the facilitator and learner versions of the modules for them, as they will need to be familiar with both.
- It is recommended that facilitators print some extra copies of checklists that will be used during the practice sessions.
- It is recommended that you print the *WHO MEC Quick Reference Chart* in color, but black and white is sufficient for all other resources.

Organizing the Printed Materials

It is recommended to organize the printed LARC LRP materials in a folder and use labeled dividers to separate the sections (i.e., for each module, add dividers for the module overview, pre–post-tests, activities, checklists, handouts, job aids, and facilitator tools). In addition, it may be useful to laminate job aids that are frequently used.

Appendix A: MCSP Monitoring PPFP Brief

USAID FROM THE AMERICAN PEOPLE

Maternal and Child Survival Program

Monitoring Postpartum Family Planning
A Challenge for Routine Information Systems

September 2017 www.mcsprogram.org

Capturing pre-discharge PPFP

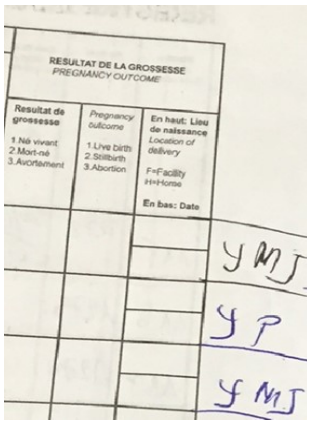
Facility registers rarely captures if a woman is postpartum when she receives family planning. As a result, the number of women receiving postpartum family planning (PPFP) is not reported in health management information systems, making it difficult to track how many women get family planning during this time of high need.

Postpartum family planning is critical to reaching FP2020 targets

PPFP coverage can be measured through surveys such as national Demographic and Health Surveys[6] or sub-national Performance Monitoring and Accountability 2020 surveys[7], but surveys are expensive and not feasible to do frequently or in all areas of a country. Also, facility and district managers need to monitor the provision of PPFP at the service delivery points they oversee. Routinely tracking the number of postpartum women receiving a family planning method could provide critical information to help with management decisions and improve services.

PPFP can be provided to women immediately after birth or to mothers in the postnatal and extended postpartum periods. PPFP may be integrated into delivery services, postnatal care, immunization, or other child health services. PPFP can be delivered at facility and community level. Tracking uptake of PPFP at all of these various contact points can be complex for routine monitoring systems. Still, tracking uptake of family planning at even one of these time points can yield important information for improving service delivery. The purpose of this brief is to share examples of how to capture the number of women who receive family planning before discharge after giving birth in a facility – one important element of PPFP. Below are examples from four countries. These approaches are used in facilities where the USAID-funded Maternal and Child Survival Program supports PPFP implementation. They are not yet part of national health management information systems (HMIS).

Rwanda's modified Delivery Register



[6] http://www.dhsprogram.com/
[7] www.pma2020.org/

Rwanda: Using the Delivery Register

To capture pre-discharge PPFP, a column is manually added (by hand) to the Maternity Register margin. Therefore, there is no need to print registers for this pilot program. Using codes, the provider documents if PPFP counseling is done (Y) and outcome:

Y/code for method accepted (MJ=jadelle, P=pills, etc.)
Y/Refuse
Y/Plan
Column remains empty if no counseling was done

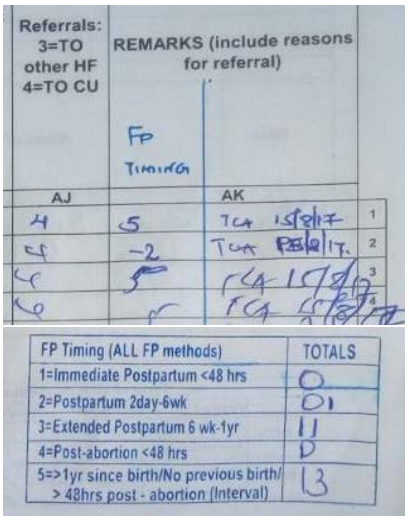
Kenya: Using the Family Planning Register

Timing of FP initiation is recorded in the "Remarks" column in the Family Planning Register using codes:

1 = Immediate Postpartum (<48 hrs)
2 = Postpartum (2day-6wk)
3 = Extended Postpartum (6wk-1yr)
4 = >1yr since birth or No previous birth
5 = Postabortion (<48 hrs)

The total for each timing category is tallied at the bottom of the page in a table. Each facility was given a stamp to create this table at the bottom of each page. Additional copies of the FP Register are kept in Labor & Delivery and/or Postnatal wards to capture PPFP at these points of service.

Kenya's modified FP Register



Madagascar: An individual form

An individual form is used to record the timing of PPFP counseling, method (IUD, implant, or other), timing of insertion, and complications at 6 weeks.

Nigeria: A separate register

New registers were developed to capture PPFP. Both registers are kept in the Labor & Delivery ward.

- A PPFP Daily Register is used to record information for each woman receiving PPFP, including details of IUD insertion.
- A PPFP Follow-up Register is used to record type of follow-up (phone or at facility), timing, and findings/complications.

Nigeria's PPFP Daily Register

Maternal and Child Survival Program (MCSP), Nigeria
POSTPARTUM FAMILY PLANNING REGISTER (DAILY PRE-DISCHARGE)

Hospital Reg. No	Date	Name of Client	Age	Phone No	No. of Living Children	Counseled during (Tick appropriate column)			PPFP counseling provided on (Tick columns done)		PPFP method given to client prior to discharge				Name of Provider who inserted PPIUD or implant	Type of PPIUD insertion (Tick appropriate column)			PPIUD instrument Used		Due date for Follow-Up
						Antenatal Care	Early Labor	Postpartum Period	HTSP	EBF	LAM +EC	Implant (*JD' IM)	IUD	POP		Post placental (within 10 min)	Immediate PP (within 48 hrs.)	Intra Caesarean	Long Placental Forceps (Kelly)	Sponge/ Ring Forceps	

Using PPFP data

Pre-Discharge PPFP uptake – the percentage of women who deliver in a health facility and initiate a modern contraceptive method prior to discharge – can be used to assess PPFP program performance at a macro (national or regional) level. This indicator can be used to identify lagging regions that may need training or leadership support or a need for large—scale efforts to change community perceptions or behaviors on family planning. Disaggregation by method can provide additionally useful information to identify training or commodity needs.

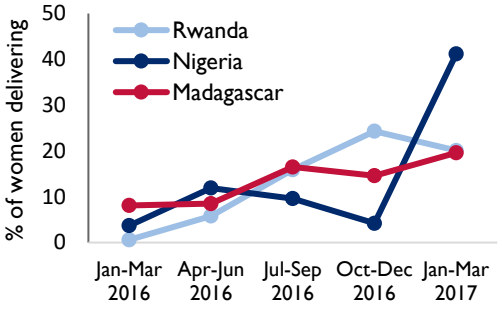
This indicator is also useful at an operational level—facility or district—for managing commodities and human resources and identifying training needs. Disaggregation by method can reveal if one method is favored, suggesting a problematic provider bias or gap in competencies. Additional indicators may also be useful at an operational level to assess facility or team performance, especially in the early stages of implementation. For example, tracking the proportion of ANC clients receiving PPFP counseling or the proportion of delivery clients receiving pre-discharge PPFP counseling can identify if a facility is giving clients timely information to encourage healthy birth spacing. Outcomes can be tracked and may be particularly important for certain methods, such as the proportion of women who received a postpartum IUD or implant that had a follow-up visit or the IUD expulsion rate.

Graph 1 shows macro level PPFP coverage among facility births in Rwanda, Madagascar, and Nigeria from January 2016 to March 2017. Graphs 2 and 3 show PPFP uptake by method in Rwanda and Nigeria. Kenya data are not yet available because providers started recording timing of FP initiation late in the MCSP program, concurrent with a training on postpartum IUD insertions. Data will be extracted from registers in late 2017 during assessments in a subset of facilities.

Rwanda

PPFP uptake increased over 15 months to 20% of women delivering. Implants are the most popular method (nearly 50% of all uptake). Few women are recorded as initiating lactational amenorrhea (LAM), although many women exclusively breastfeed in Rwanda. Program staff learned providers hesitate to record LAM since women may not continue exclusive breastfeeding, although other short-acting methods (such as condoms and pills) can also be easily discontinued. Rwanda had a large number of records with an undocumented method, mostly due to not reporting the number of woman accepting oral contraceptive pills. MCSP continues to support improvements in data quality.

Graph 1. Percent of women who delivered at MCSP-supported facilities and initiated an FP method prior to discharge



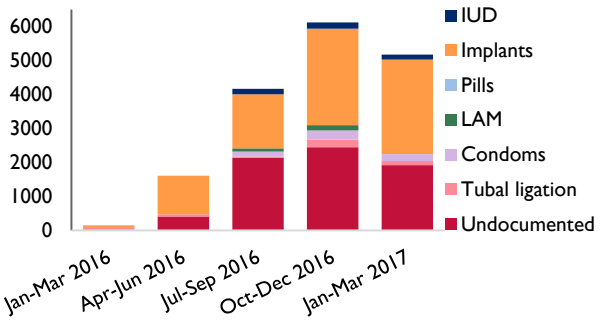
Madagascar

PPFP uptake increased, reaching 20% in the most recent quarter. MCSP-supported facilities use SMS to report data monthly. This platform allows fast reporting of PPFP uptake, but not disaggregation by method.

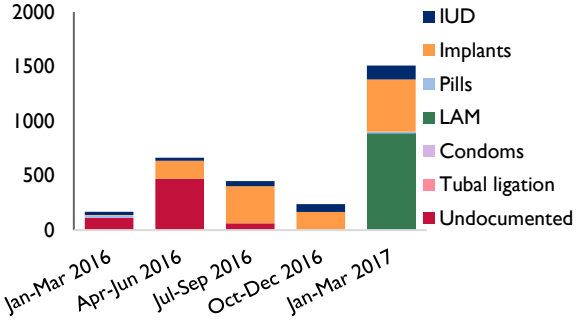
Nigeria

There were increases in the number of postpartum women choosing implants (from 4 women Jan-Mar 2016 to 479 women Jan-Mar 2017) and IUDs (from 30 Jan-Mar 2016 to 127 women Jan-Mar 2017). However, the spike in early 2017 was mainly due to recording bias, since providers started to capture the number of women choosing LAM in January 2017. LAM was the most popular method, chosen by nearly 60% of all women adopting PPFP Jan-Mar. The dip in Oct-Dec 2016 was likely due to health system disturbances, including a health worker strike in one of the two states where MCSP operates.

Graph 2. Rwanda pre-discharge PPFP uptake by method



Graph 3. Nigeria pre-discharge PPFP uptake by method

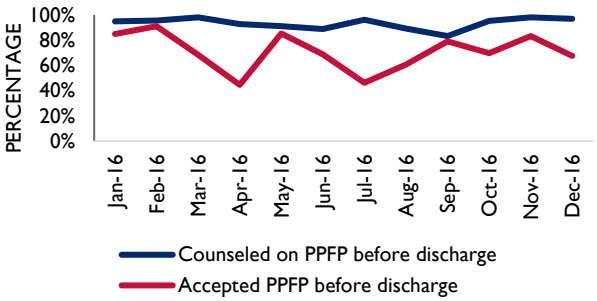


District and Facility Use of PPFP Data

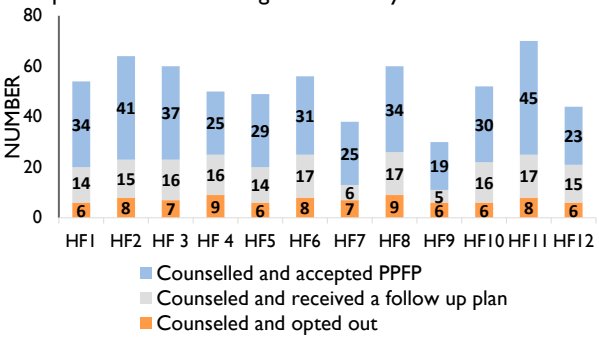
As mentioned, additional data may be used at an operational level to inform program management. **Rwanda** has proposed facility and district dashboards to review PPFP program performance. Dashboards would track:

- Provider skills level (assessed during supervision)
- Commodity stock-outs
- Pre-discharge PPFP counseling and acceptance (mock-up shown in Graph 4)
- PPFP counseling outcomes by month or facility (mock-up shown in Graph 5)
- Pre-discharge PPFP uptake by method
- Management actions and responsible person

Graph 4. PPFP Counseling and acceptance (N = deliveries)



Graph 5. PPFP Counseling outcomes by HF



In **Nigeria**, MCSP supported 20 sentinel facilities to form Quality Improvement (QI) teams. Dashboards were tested by the QI teams and will be used to regularly review 16 key indicators of quality of care on the day of birth, including pre-discharge PPFP counseling and uptake.

Summary

PPFP is critical to reaching the FP2020 goals adopted by 50 countries, so measuring the number of women who receive PPFP must be incorporated into national registers and reporting systems to track facility or program performance. Collecting pre-discharge PPFP uptake has shown to be feasible, and a notable proportion of women choose to start a family planning method immediately after delivery, if services are available. Thus coverage of pre-discharge PPFP is a suitable indicator for national HMISs.

Changing existing registers is a lengthy process that requires advocating to the MOH, who must balance numerous requests for more data elements without overburdening their records and their health workers. Increasingly, indicators must be tested for feasibility and usefulness, before they can be added to registers. Still, we have demonstrated several ways in which pre-discharge PPFP can be captured in the interim, without revising and reprinting existing registers. Assessing how well health workers manage these proposed changes can also inform permanent changes to the national HMIS.

Recommended indicator for national HMIS:
Proportion of women delivering at facility who initiate a modern contraceptive method prior to discharge

Rwanda's solution for recording pre-discharge PPFP requires minimal documentation burden for providers because they do not need to record the same information (client name, age, etc.) in multiple registers. It is also cost-effective because multiple registers do not need to be printed. However, it has challenges that need to be considered when revising registers and writing new instructions for providers and HMIS personnel: using codes for each method can be difficult to tally, so data quality must be regularly checked. In addition, adding one or two columns to a delivery register does not allow systematic recording of follow-up or bad outcomes, such as infections or IUD expulsions.

MCSP will continue to support testing PPFP indicators and advocate for inclusion into national HMISs. In addition to facility-based, pre-discharge PPFP, MCSP is also exploring how to capture PPFP at other points of contact after a birth and PPFP referrals given to postpartum women accessing other health services.

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Appendix B: Learner Assessment

Assessment of **learner knowledge** will be done through pre- and post-test questionnaires at the beginning and completion of each module. Assessment of **learner skills** will be done through observation of the procedure by the facilitator at a skill station (complete with model and instruments) using a checklist (see *Using the Skills Checklists).*

Learners must pass the knowledge assessment before attempting the skills assessment. However, they may practice the skill before retaking the knowledge assessment, as mentored practice often helps clear up misunderstandings and gaps. Learners should review the module, discuss any areas that they do not understand with the facilitator, and then be allowed to retake the knowledge assessment.

If a learner passes the knowledge assessment but is not able to demonstrate competently all the required skills, the learner should continue to practice the deficient skills, discuss with the facilitator or another competent learner any areas that are not well understood, and be allowed to retake the skills assessment.

For learners who are not performing to standard, additional support is recommended through ongoing peer support and mentorship (see Step 6 of the *Implementation Process*). Although it is desirable that all learners succeed in demonstrating competence in the amount of time planned, the mastery learning method of instruction assumes that **all learners can become competent given sufficient time and opportunity to study and practice.** Learners will often become successful at different rates, and some learners will need more practice than others.

Competency Certification

A competency certificate should be issued by the facilitator only after ensuring that a learner's skills have been assessed.

The learner is assessed as competent when he or she:

1. Is able to pass a post-module knowledge assessment with score of 85% or higher, *and*
2. Is able to demonstrate the skills for each module at a 100% level of competence.

Due to lack of clients during the training period, the assessment for competency may be done after the training when the learners have adequate time to perform (under supervision of LARC facilitators or PPCs) the appropriate numbers of cases on clients, as listed in Table A1. The facilitator needs to be sure that PPCs inform them when a learner has practiced sufficiently and is ready to be assessed on a skill.

Table A1. Number of insertions/removals to be performed for competency certification

Technical Skill	Cases Observed	Cases Performed on Model	Cases Performed Successfully on Client Under Supervision
Interval IUD	2	2	2
Hormonal IUD	2	2	2
Postpartum IUD	2	2	1
Postabortion IUD	1	2	1
Implant Insertion	2	2	2
Implant Removal	2	2	2

Keeping Track of Learner Competence

Appendix E is a *Learner Mentoring Plan* for use in recording the learners who need to practice certain skills. This plan provides space for all 10 LARC LRP modules. The mentoring plan will help the facilitator stay organized and see the progress of each learner at a glance.

Appendix F, *Participant Tracking Matrix,* is a tool for facilitators to keep track of the total number of modules completed by each participant, the status of certification of each module, and also gives facilitators a clear picture of the status of trainings completed in each facility.

Using the Skills Checklists

Skills checklists provide a standard way of performing the steps of a procedure. They are used for four purposes:

1. Demonstration of skills
2. Skills practice
3. Peer practice
4. Skills assessment

Learners are not expected to perform all of the steps or tasks correctly the first time they practice them. Instead, the checklists are intended to:

- Assist in learning the correct steps and the sequence in which they should be performed (**skill acquisition**).
- Measure progressive learning in small steps as the learner gains confidence and skill (**skill competency**).

Before using a checklist, the facilitator should briefly review it with the learners. In addition, each learner should have the opportunity to witness a skill as the facilitator demonstrates it on a training model and/or to observe the activity performed in the clinic with a client. Thus, by the time the group breaks up into teams to begin practicing on models and rating each other's performance, each learner should be familiar with the steps in the checklist. When used to demonstrate skills, the facilitator should talk through the steps as they perform them, explaining the thought process (the "why") as they go through them.

Used consistently, the checklists enable learners to chart their progress and identify areas for improvement. The checklists are designed to make communication (mentoring and feedback) between the learner and facilitator easier and more helpful.

The learner and facilitator should work together as a team. For example, before the learner attempts the skill or activity (e.g., implant insertion) for the first time, the facilitator or mentor should briefly review the steps involved and discuss the expected outcome. In addition, immediately after the skill or activity has been completed, the facilitator or mentor should meet with the learner. The purpose of this meeting is to provide positive, constructive feedback about the learning progress and to define the areas (knowledge, attitude, or practice) where improvement is needed in subsequent practice sessions. Over time, as learners become more competent, they perform more and more independently.

Appendix C: Facility Readiness Assessment Tool

Instructions for the assessor(s):

1. Contact the in-charge at the facility and other key staff and inform them of the purpose of your visit.
2. At every point of the assessment, introduce yourself and explain the purpose of your visit.
3. Walk through the relevant areas: counseling room, FP clinic, antenatal care (ANC) area, labor room, PNC (postnatal care/postpartum ward, operating theater, and check the appropriate boxes in the tool, providing remarks for any gaps observed.
4. Complete the tool before leaving the facility so that you can immediately share the results with the facility staff.
5. Thank the facility staff for their time.

Name and designation:

Assessors 1: _____

Assessors 2: _____

Date of visit: _____

Persons interviewed: (Name & Designation)

1. _____
2. _____
3. _____
4. _____
5. _____

General information:

A1. Name of the district:_____

A2. Name of the facility:_____

A3. Type of Facility: ☐ Tertiary Care ☐ District/County Hospital ☐ Health Center ☐ Other

B. FP Services and Staffing Available for LARCs

	Tick (✓) services/ methods provided at this facility	Number of staff providing each service							
		Physicians		Midwives		Nurses		Other	
		# providing service	# trained in past 2 years	# providing service	# trained in past 2 years	# providing service	# trained in past 2 years	# providing service	# trained in past 2 years
FP counseling									
Interval IUD insertion (Copper T and hormonal*)									
Postpartum IUD insertion (Copper T and hormonal*)									
Postabortion IUD insertion (Copper T and hormonal*)									
IUD removal									
Implant insertion									
Implant removal									

*Note if providers not trained in hormonal IUDs:_____

Location of services

Where is FP counseling done in this facility? (tick all that apply)	❒ ANC clinic ❒ L&D/Maternity ❒ Postpartum ward ❒ PNC Clinic ❒ FP Clinic ❒ Other
Where are FP services provided in this facility? (tick all that apply)	❒ ANC clinic ❒ L&D/Maternity ❒ Postpartum ward ❒ PNC Clinic ❒ FP Clinic ❒ Other
Are immediate PPFP services provided at this facility? (predischarge)	❒ Yes ❒ No
If yes to immediate PPFP, what methods are provided to women immediately after birth and pre-discharge in this facility?	❒ IUD ❒ Implants ❒ Pills ❒ Injectables ❒ TL/Minilap ❒ Condoms ❒ LAM ❒ Other

C. Infrastructure/equipment/supplies available for LARC services

Information	Available?		In good condition or stored properly?		Remarks (note if equipment not functioning, commodities are expired, etc.)
	Yes	No	Yes	No	
Infrastructure and equipment					
Information on LARC services posted					
Water supply where LARC services are provided					
Light sources where LARC services are provided					
Examination room with privacy					
Examination table					
Examination light					
Curtains/screen for privacy					
Sphygmomanometer/BP apparatus					
Stethoscope					
Equipment and supplies for infection prevention					
Gloves					
Disinfectant (0.5% chlorine)					
Antiseptic (chlorhexidine, povidone-iodine, alcohol, etc.)					
Plastic buckets for decontaminating used instruments					
Boiler/autoclave					
Color-coded dustbins					
Detergent for cleaning instruments					
Brush for washing instruments					
Appropriate method for waste disposal (pit, incinerator, outsource)					
Instruments/supplies for interval IUD insertion and removal					
Instrument tray with lid					

Information	Available?		In good condition or stored properly?		Remarks (note if equipment not functioning, commodities are expired, etc.)
	Yes	No	Yes	No	
Kidney Tray 8"					
Iodine cup 250 ml					
Tenaculum forceps 10"					
Sponge forceps 9 1/2", straight					
Cheatle forceps 10 1/2"					
Sims scissors 8", Curved					
Uterine sound					
IUD removal forceps/alligator jaw 8"					
Speculum, medium/large					
Additional instruments/supplies for PPIUD					
Kelly placenta forceps 12", curved					
Sims speculum, large					
Instruments/supplies for implant insertion and removal					
Instrument tray with lid					
Iodine cup, 250 ml					
Tissue forceps, spring-style, 1x2 teeth, 13 cm					
Tissue forceps, spring-style, toothless, 13 cm					
Jadelle trocar (if Jadelle is used at this facility)					
5 cc syringe with 22 gauge 1 1/2" disposable needle					
Surgical blade with handle					
Hemostatic mosquito forceps straight, 13 cm					
Hemostatic crile forceps curved, 14 cm					

Information	Available?		In good condition or stored properly?		Remarks (note if equipment not functioning, commodities are expired, etc.)
	Yes	No	Yes	No	
Implant removal ring forceps 2.2mm					
Dissecting forceps					
LARC commodities					
IUD (Copper T380A)					
LNG-IUS (hormonal IUD)					
Implant (one rod)					
Implant (two rods)					

D. Recordkeeping and data extraction

	Has place to record if client received FP counseling?		Has place to record if client received FP method?		Has place to record the method received?		Remarks
	Yes	No	Yes	No	Yes	No	
ANC register							
FP register							
Maternity/ delivery register							
PNC register							
PAC register							
ANC card kept at facility							
ANC card kept with client							
FP card kept at facility							
FP card kept with client							

Describe any other registers or individual records where FP counseling or services are recorded:

	Is this data recorded in this facility?		Is this data aggregated for monthly facility reporting forms?		Remarks
	Yes	No	Yes	No	
Type of IUD inserted (Copper T vs hormonal)					
Type of implant inserted (1 vs 2 rod)					
IUD insertions by client age					
Implant insertions by client age					
PPIUDs inserted					
PP Implants inserted					
IUDs after postabortion services					
Implants after postabortion services					
IUD removals					
Implant removals					
Follow-up visits after LARC services					
Complications due to LARCs					

Are dashboards displayed for LARCs? Describe if and how LARC data are displayed or reviewed in the facility:

Services provided in the last 3 months

Fill in the names of the past 3 completed months. Gather the number of services provided each month from the facility's tally sheet or reporting form, or calculate the number by tallying from the register. If data are not recorded (e.g., PPIUDs), write "Not available." Then calculate the average for the past 3 months.

	Number for each of the past 3 months			Average for 3 months
	Month 1	Month 2	Month 3	
Total number of deliveries				
Normal deliveries				
Cesarean deliveries				
PAC clients				
Number of FP clients receiving:				
All IUDs				
If available, record disaggregations:				
Copper IUD				
LNG-IUS				
PPIUD				
IUD after an abortion				
Interval IUD				
All implants				
If available, record disaggregations:				
PP implant				
Implant after an abortion				
Interval implant				

E. Referrals

Do you receive clients referred from other health facilities for LARC services?	❒ Yes ❒ No
If yes, approximately how many LARC clients have been referred from other facilities in the last 3 months?	
Do you receive clients referred from community health workers for LARC services?	❒ Yes ❒ No
If yes, approximately how many LARC clients have been referred by community health workers in the last 3 months?	
Do you refer LARC clients to other facilities?	❒ Yes ❒ No
If yes, why?	

F. Action plan

Gaps Identified	Causes of Gaps	Action Steps	Person(S) Responsible	Timeline

Appendix D: Training Preparation Checklist

To be used by LARC facilitator

Task	Remarks	Status (Completed/Not Completed)
Advance Preparation (logistics)		
Arrange and meet with facility in-charge to confirm training dates and share the schedule for training.		
Request that the facility in-charge identify and invite learners to be trained for the provision of LARC services. (Ideally, learners/staff from the labor & delivery/maternity ward, postnatal ward, maternal and child health services, and family planning clinic will all be invited.)		
Work with the facility in-charge to ensure they arrange for advance promotion so that interested LARC clients are available during the training.		
Ensure learners are informed before the training about the time and place for training.		
Look at the training room/space in advance. It should be fairly comfortable and accommodate chairs and tables and have electricity. It should not be in a busy place.		
Request that the facility in-charge designate one person from the facility to set up the training room prior to the training start date.		
Look at the registers in the labor ward, post-natal care, maternal/child health and FP clinic. Share any updated tools with facility in-charge and request to modify the existing data collection tools register, if needed.		
Go through the *Module Overview for Facilitator* of each module in detail and prepare and practice for facilitation.		
Ensure that you have the necessary training materials ready to take with you. (Each module has a list of materials and supplies on page 2 of the *Module Overview for Facilitator*) as well as paper, pen and writing pads for the participants.		

Task	Remarks	Status (Completed/Not Completed)
Ensure all training-related documents are printed (i.e. facilitator and learner version of each module) and that you have a projector to show any slide presentations or videos.		
Day Before Training/On The Morning of the Day of Training		
Ensure that the staff is informed and ready for clinical sessions/site visits.		
Ensure the sites have done advance promotion so that interested LARC clients are available.		
Set up classroom for group facilitation.		
Set up simulation stations (using the guidance provided in the *Module Overview for Facilitator*).		
Ensure that tea/snacks have been arranged.		

Appendix E: Learner Mentoring Plan

Name of the learner: _____ Learner's contact number: _____ Training Date: _____

Name of the mentor: _____ Name of Peer Practice Coordinator: _____

Name of the facility: _____ Module name & number: _____

Skills to be practiced (refer to skills checklist(s) for the skills that need practice): _____

_____

Date	Time	# Of Coaching Sessions	Skills Coached	Satisfactory/ Unsatisfactory	Date & Time for Next Coaching Session (If Needed)	Notes/Status	Signature

Challenges: _____

Recommendations: _____

Achievements: _____

Appendix F: Participant Tracking Matrix

Name of Participant	Name of Facility	Module Status (e.g.: Training Completed, Learner Certified)										
		Mod 1	Mod 2	Mod 3	Mod 4	Mod 5	Mod 6	Mod 7	Mod 8	Mod 9	Mod 10	Comments*

*Please include any additional observations here, including if trained staff were transferred to another unit or facility.