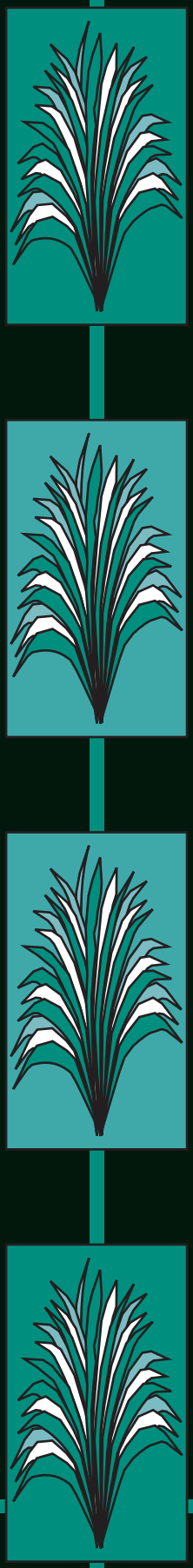

ACQUIRE Evaluation and Research Studies

Increasing Awareness and Use of Long-Acting and Permanent Contraceptive Methods in Guinea: Case Study of a Pilot IUD Intervention

E & R Study #9 ◆ May 2008

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the ACQUIRE project

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Increasing Awareness and Use of Long-Acting and Permanent Contraceptive Methods in Guinea: Case Study of a Pilot IUD Intervention

E & R Study #9 ♦ May 2008

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Acronyms/Abbreviations

ACQUIRE	Access, Quality, and Use in Reproductive Health
ADRA	Adventist Development and Relief Agency International
AGBEF	Association Guinéenne pour le Bien-être Familial (Guinean Association for Family Well-Being)
BCC	behavior change communication
CTU	contraceptive technology update
CYP	couple-year of protection
DHS	Demographic and Health Survey
FP	family planning
IEC	information, education, and communication
IP	infection prevention
IUD	intrauterine device
LAPM	long-acting and permanent method [of family planning]
MOH	Ministry of Health
PLA	participatory learning approach
PNA	performance needs assessment
PRISM	Pour Renforcer les Interventions en Santé Reproductive et MST/ SIDA (Strengthening Interventions in Reproductive Health and STD/AIDS)
RH	reproductive health
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WST	whole-site training

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Executive Summary

In 2004, the ACQUIRE Project[1] in Guinea, in partnership with the country's Ministry of Health (MOH), implemented a three-phase project to increase access to and awareness of long-acting and permanent methods of family planning (LAPMs) particularly the intrauterine device (IUD), and to increase the MOH's capacity to provide these services. This case study provides a brief contextual overview of the first two "formative" phases of the project—a performance needs assessment (PNA) of LAPM service provision and a qualitative research project that explored community awareness of and barriers to LAPMs. (Both phases have been described in detail in previous reports [The ACQUIRE Project, 2005; Escandon et al., 2006].) This report emphasizes the final phase of the project, a pilot intervention using "supply and demand" interventions to increase awareness of and access to the IUD in the upper region of Guinea. For the purpose of this project, the term "supply and demand" refers to a combination of interventions that include health care provider training, the provision of high-quality products, and the development of tools such as job aids (the "supply"-side inputs), along with a variety of communication activities to inform key stakeholders and potential clients about the IUD, how the method works, what the benefits and contraindications are, and where to obtain IUD services (the "demand"-side inputs).

The PNA conducted as part of the project's first phase identified a number of recommendations at the client, provider, and system levels to address performance gaps in the provision of LAPMs. At the client level, these interventions included the development of a communications campaign, which involved community and media efforts, to increase client awareness, knowledge, and use of the IUD. Additional activities benefiting clients included the training of community health agents to disseminate LAPMs and a community study to understand opportunities for and barriers to family planning and LAPMs. Interventions at the provider level included updating providers' knowledge of LAPMs, clarifying job expectations of service providers with regard to LAPMs, updating communication materials to include more information regarding LAPMs, and developing job aids to reinforce family planning messages. Interventions at the system level included prioritizing family planning and LAPMs for the MOH, orienting supervisors to give providers family planning performance feedback and to clarify expectations with regard to the provision of LAPM-related information, and strengthening the management of logistics and supplies to prevent stock-outs of family planning methods and other materials at health facilities.

The second phase of the project consisted of a qualitative study (conducted in collaboration with Family Health International) to bring further clarity to supply and demand issues related to family planning in Guinea and to identify community awareness of, and barriers to, LAPMs. This study found a cultural context favorable to the introduction of birth spacing methods but not to the use of permanent methods of contraception. In particular, the study found the prospects for introducing the IUD, a long-acting but not permanent method, to be quite positive. Women either knew very little about the method or had heard primarily positive things about it. The IUD also has three

[1] The ACQUIRE Project (which stands for Access, Quality, and Use in Reproductive Health) is a Leader with Associate Cooperative Agreement awarded by the U.S. Agency for International Development (USAID) in late September 2003 to EngenderHealth, in partnership with Adventist Development and Relief Agency International (ADRA), CARE, IntraHealth International, Inc., Meridian Group International, Inc., and the Society for Women and AIDS in Africa. The ACQUIRE Project's mandate is to advance and support reproductive health and family planning services, with a focus on facility-based services and clinical care.

characteristics women noted to be most important in terms of using a family planning method: discreetness, minimal side effects, and an immediate return to fertility after discontinuation. Among both men and women, misconceptions about the IUD were common. This study thus played a critical role in informing the objective and content of the third phase of the project: a pilot intervention to raise community and client awareness of the IUD and to strengthen the capacity of MOH facilities to provide IUD services in Upper Guinea.

The third phase of the program was a pilot intervention with two components aiming (1) to support an increase in high-quality services at the clinical level (the supply side) and (2) to simultaneously provide consumers with appropriate information to increase their knowledge about the IUD and to make an informed choice about whether this method would meet their reproductive health needs (the demand side).

ACQUIRE's primary inputs on the supply side consisted of training health care workers in the district's provincial hospital and in six health centers in the areas of counseling, infection prevention, and IUD insertion and removal, to ensure that hospital and health center staff were prepared to counsel clients on the IUD and to correctly insert or remove the IUD.

The demand side of the intervention, developed with the technical assistance from ACQUIRE partner Meridian Group International, Inc., consisted of three major types of activities: a communications campaign; outreach to religious leaders to create an enabling environment; and community mobilization activities. The target audiences for this campaign (determined primarily through the qualitative research study) were married women 25–40 years old, married men about 40 years old with multiple wives and numerous children, service providers, and religious leaders.

The campaign messages, materials, and channels used emerged through insights gained during the qualitative research study. The primary channels used to reach the target audience were print (posters, brochures), rural radio, and interpersonal communication. These forms of communication were chosen based on cultural preferences for interpersonal and community-level communication channels, the specific geographic area involved, the limited budget available, and the lack of local capacity in advertising and communication services. An initial set of communications campaign messages and materials were developed and underwent extensive pretesting to clarify and confirm the appropriateness of both the messages and their presentation. The final campaign theme included the following tag line "*Un contraceptif ideal pour espacer les naissances*" (an ideal contraceptive for spacing births).

Key benefits of the method were highlighted on all print materials and in radio messages: namely, that the IUD is effective and discreet, is easy to use, is a long-acting method, and has few side effects. Language issues were an important consideration in the development of this campaign. Radio and interpersonal channels used Mandingo, the predominant local language, while print materials were written in French and N'ko.

The print aspect of the communications campaign consisted of a consumer brochure, a poster listing sites offering the IUD, a poster featuring a traditional Muslim family with three children, a poster featuring a relatively affluent family with two children, and a poster featuring a woman stating that she has used the IUD for two years without any problems. Two additional print materials were developed in support of clinical training activities: (1) a poster to be displayed at the clinic with reminders about key counseling points, and (2) a job aid in the form of a brochure, "What Health Workers Need to Know," which summarized the IUD's mechanism of action, eligibility criteria, and side effects and included reminders about counseling and service-delivery issues.

During January through October 2006, a series of radio programs, including roundtables and question-and-answer programs featuring a variety of perspectives, disseminated information about the IUD on a regular basis. These programs alternated between "microprograms" (five minutes daily), which highlighted the IUD's benefits and directed clients to specific health centers for additional information, and "magazine programs," which allowed for more detailed dissemination of messages and featured interviews with health providers, satisfied users, and community leaders.

This communications campaign placed special emphasis on leveraging radio and print efforts by linking to strong community structures. ACQUIRE convened a two-day meeting of religious leaders in Siguiri in March 2006, in collaboration with the League of Islamic Affairs and the Siguiri District Health Officials. A primary objective of this meeting was to discuss with the religious leaders the benefits of family planning methods, including long-acting methods such as the IUD, so that they would serve as champions of the campaign. This dialogue aimed to create an enabling environment that would facilitate dissemination of information about the IUD to married couples through radio, print, and direct communication. Communities were also engaged in dialogue through the Participatory Learning Approach offered through the technical assistance of ACQUIRE partner CARE provided to the Adventist Development and Relief Agency International.

Monitoring and evaluation activities included developing indicators to monitor project results, refining tracking and reporting mechanisms for service-delivery statistics, and designing and implementing a client intake form to assess exposure to and recall of campaign messages among clients of each of the seven targeted health facilities.

Service statistics and client intake results indicate that the ACQUIRE communications campaign, coupled with improvements in IUD supply, succeeded in attracting a large number of new clients to the IUD. Specifically, 700 new IUD users were served in ACQUIRE-supported facilities in 2006—an almost ninefold increase compared with the previous year (2005), and a 19-fold increase compared with 2004. During the same period, the number of users of other family planning methods, such as Depo-Provera and oral contraceptives, remained virtually static. Two facilities reported that the demand for the IUD exceeded the supply: These facilities did not order a sufficient quantity of IUDs initially, and later were unable to obtain them from the MOH due to a stock-out in the regional warehouse of the Guinea Central Pharmacy. The number of new IUD clients is especially notable, given the disruption of the IUD supply at these two sites due to the stock-out situation. It is also important to note that the seven participating facilities reported 225 new IUD users in 2007, the year following the active intervention phase. This figure, while lower than that in 2006, remained significantly higher than those in 2005 and 2004.

Client interviews conducted at the health facilities confirmed that almost half of the men and the majority of women had heard of the IUD, and campaign message recall was high. Rural radio appears to have been a particularly important source of information about the IUD, followed by providers and friends from a women's group, or *séré*. Men reported more exposure to print resources than did women. Women seeking IUD services were significantly more likely than women seeking other family planning services to learn about the method from a friend in a *séré*, from a community mobilizer, or from a brochure, suggesting that these sources were particularly influential in affecting a woman's decision to seek IUD services. Women seeking IUD services were also significantly more likely to report having heard a radio roundtable discussion with local imams, suggesting that the involvement of religious leaders in campaign messages may have played an important role in women's decisions.

This case study illustrates the effectiveness of a synergistic "supply and demand" strategy that includes the engagement of religious and district MOH officials to increase awareness and knowledge of long-acting family planning methods in a low-resource setting in West Africa. This communications campaign was implemented with minimal monetary investment, in a context with clinical supply challenges, little local marketing capacity, a limited range of media, and a relatively conservative religious culture. Despite these challenges, the campaign succeeded in reaching the intended audience with relevant information that translated into a considerable number of women seeking IUD services and making an informed choice to use the IUD within a period of a few months time.

Program Insights

1. **Seek stakeholder involvement early in the process.**
   Interventions must be tailored to suit the specific context in which one is implementing a program; therefore, *early stakeholder involvement* is important to identify the specific needs of a community and to ensure that interventions are targeted accordingly. This involvement can come in the form of stakeholder meetings or PNAs to discuss the problems and prioritize the issues that the program can address. Key community gatekeepers, such as community leaders or religious figures and district MOH officials, should be brought in early to provide input to and support for the initiatives.
2. **Assess community attitudes before creating communications materials.**
   Assessing community attitudes and barriers that impede the utilization of LAPMs is necessary if a communications campaign is going to effectively target these barriers. In Guinea, this was achieved by conducting a qualitative assessment of attitudes toward LAPMs. While resources may not always be available for indepth assessments or studies, smaller scale focus group discussions also can provide critical insights into community attitudes. Community attitudes must be ascertained before a communications campaign is developed.
3. **Solicit stakeholder input and pretest campaign messages before finalizing communications efforts.**
   Stakeholders such as community volunteers can provide valuable insights into campaign materials, and involving them in the development process will help foster ownership of those materials. Pretesting campaign messages and materials will help identify which messages are most appropriate and accepted by both stakeholders and the community. In this initiative, pretesting the print materials yielded invaluable insights from members of the target audience. Pretest results led to a number of wording and graphics changes , that ultimately strengthened the impact of the messages.
4. **Involve religious leaders to help create a favorable environment for communications campaigns.**
   The IUD campaign's outreach efforts with Muslim leaders, particularly the roundtables with imams that were aired on rural radio, may have played an important role in disseminating messages about the IUD and in promoting the acceptability of the method. Data from client interviews showed that women seeking IUD services were significantly more likely than women seeking other family planning services to report having heard the imam roundtable on the radio.

Lessons Learned

1. **Rural radio is an effective way of disseminating family planning information in a low-resource setting, while interpersonal communications efforts can simultaneously strengthen the effectiveness of communications messages.**

Among the men and women who reported having heard of the IUD, 45% of men and 76% of women said they heard about it through rural radio. Overall, rural radio was the most common source of information about the IUD. Interpersonal communication and peer influence also played important roles in increasing knowledge about the IUD; results from client intake interviews showed that women seeking IUD services were significantly more likely than women seeking other family planning services to have received information about the IUD from a friend in a *séré*.

2. **A targeted communications campaign conducted in a low-resource setting with short bursts of advertising and promotion can be extremely effective.**
   The Guinea IUD experience demonstrates that dramatic increases in method use can occur when well-targeted, relevant messages are disseminated with a minimal communications budget. As many as 700 new IUD users were served in ACQUIRE-supported facilities during the communications campaign in 2006, compared with 82 in 2005 and 37 in 2004.

Recommendations

1. **There must be a steady supply of commodities and enough trained providers before communications activities that aim to increase awareness of and knowledge about the IUD are implemented.**
   Because of stock-outs, two of the health facilities were unable to adequately satisfy client demand. Prior to the implementation of demand-generation activities, it is necessary to coordinate with the MOH to ensure that there is a steady supply of commodities and that facilities have a mechanism to secure additional supplies in a timely manner, if necessary.
2. **Short bursts of advertising and promotion have limited impact in the long term; communications activities should be sustained for long-range impact.**
   Short-term communications campaigns have a short-term impact. The number of new IUD users at the seven targeted facilities declined from 700 during the active project phase in 2006 to 225 in the year following the project (2007). Audiences need to receive messages multiple times, through various channels, if knowledge, attitudes, and practices are to be shifted to a sustained level of behavior change. Nonetheless, the 2007 levels of IUD acceptance were still much higher than those in the preintervention phase, pointing to a possible residual effect of the campaign.

Introduction

In 2004, the ACQUIRE Project[2] in Guinea, in partnership with the country's Ministry of Health (MOH), implemented a three-phase project to increase access to and awareness of long-acting and permanent methods of family planning (LAPMs), particularly the intrauterine device (IUD), and to increase the MOH's capacity to provide these services. This case study describes the context of family planning in Guinea, briefly discusses the first two "formative" phases of ACQUIRE's project in Guinea, and then describes the third phase of the project—a pilot intervention using supply and demand strategies to increase awareness of and access to the IUD in the Upper Guinea (Haute Guinée).

Information for this case study was gathered through a review of internal documents, such as project work plans and activity reports, as well as through analysis of service statistics and client intake interviews.

The Context of Family Planning in Guinea

Guinea is ranked 160th out of 177 countries in the Human Development Index published by the United Nations Development Program (UNDP). The country's adult literacy rate is 30%, and the combined primary, secondary, and tertiary school gross enrollment ratio is 42% (UNDP, 2006). The majority (85%) of the country's population is Muslim, while most of the remaining population adheres to traditional beliefs.

Maternal, infant, and child health outcome indicators illustrate the dire situation of women and children in Guinea. Maternal death rates are among the highest in the world, with the maternal mortality ratio estimated at 980 maternal deaths per 100,000 live births (DNS et ORC Macro, 2006). Of the 192 World Health Organization (WHO) member states, Guinea ranks 171st for mortality among children under age 5 (150 deaths per 1,000 live births), and has an infant mortality rate of 98 deaths per 1,000 live births (UNICEF, 2007).

Family planning indicators similarly show a significant need for improvement. Use of contraception, recognized as an important way of preventing maternal mortality and promoting birth spacing conducive to better infant health, is quite low in Guinea. While 91.8% of married women of reproductive age were found to be aware of at least one method of family planning in 2006, a closer examination shows that family planning knowledge was skewed toward the pill (82.4%), male condoms (79.0%), and injectables (78.0%). Levels of knowledge of female sterilization, the IUD, and vasectomy were considerably lower, at 39.0%, 12.2%, and 4.2%, respectively. Actual contraceptive prevalence is quite low: The use of any modern contraceptive method among married women of reproductive age was 6% in 2006, and reliance on female sterilization and IUD in this population did not exceed 2.0% (DNS et ORC Macro, 2006).

[2] The ACQUIRE Project (which stands for Access, Quality, and Use in Reproductive Health) is a Leader with Associate Cooperative Agreement awarded by the U.S. Agency for International Development (USAID) in late September 2003 to EngenderHealth, in partnership with the Adventist Development and Relief Agency International (ADRA), CARE, IntraHealth International, Inc., Meridian Group International, Inc., and the Society for Women and AIDS in Africa. The ACQUIRE Project's mandate is to advance and support reproductive health and family planning services, with a focus on facility-based services and clinical care.

The unmet need for family planning is evident in Guinea. Among married women, the unmet need for family planning is 21.2%, with 13.1% of women expressing a desire to space births and 8.1% expressing a desire to limit pregnancies. Younger women (between the ages of 15 and 34) tend to indicate a desire to space births, but among women who are 35 years and older, demand shifts to limiting births (DNS et ORC Macro, 2006).

Lack of availability and of knowledge, and religious and social factors have been identified in prior studies as representing barriers to the use of contraception. In describing the PRISM project's media campaign in Guinea, Blake and Babalola (2002) noted that spouses rarely discussed family planning and indicated that support for modern family planning methods was low. A qualitative study conducted among Guinean youth (aged 15–24) in N'Zerekore, Faranah, and Kankan indicated that although youths were highly aware of contraception, their knowledge was cursory and they had much misinformation about specific contraceptive methods (Johns Hopkins Bloomberg School of Public Health/CCP, 2003). In another study conducted with unmarried men and women, aged 15–24 living in Faranah, Kissidougou, and Gueckedou, distrust of modern methods abounded (Görgen et al., 1998). Participants in these discussions associated modern contraception with infertility and with increased promiscuity and prostitution, especially among young women. Surveys of religious leaders in the N'Zerekore, Faranah, and Kankan regions found that about one-third believe that use of contraceptives could encourage adultery (Blake & Babalola, 2002). Some also believe that specific methods are forbidden by Islam—in particular, permanent surgical methods.

Service-delivery issues also must be considered to better understand the lack of availability and knowledge of family planning in Guinea. Under the dictatorship of Sekou Toure, the country had experienced generations of pronatalist policies and practices. In 1992, however, the Guinean government adopted a national population policy and began integrating family planning services into the public health sector (Stewart, Stecklov, & Adewuyi, 1999). Since this time, the MOH has set ambitious goals for health and family planning, including an increase in contraceptive prevalence to 25% by 2010. The *MOH Family Planning Norms and Protocols* document delineates that the following family planning services be offered at health posts, health centers, and hospitals:

- Health posts: condoms and spermicides
- Health centers: condoms, progesterone-only oral contraceptives, combined oral contraceptives, injectables, and IUDs
- Hospitals: condoms, progesterone-only oral contraceptives, combination oral contraceptives, injectables, minilaparotomy services, and IUDs.[3]

Despite the important advances in family planning service provision, significant gaps in these services remain. A health facility survey conducted in Guinea in 2002 identified a lack of essential equipment for reproductive health services, a lack of IUD commodities, and little mention of IUDs during family planning consultations. Evaluators noted that counseling was primarily focused on injectables and oral contraceptives, which were also the two methods clients most frequently requested initially. Service providers mentioned the IUD in only 15% of consultations, but the method was available in only 10% of the facilities surveyed (Eckert et al., 2002).

Currently, more than three-quarters of clinics offering family planning services in Guinea are operated by the Association Guinéenne pour le Bien-être Familial (Guinean Association for Family Well-Being), or AGBEF. AGBEF has its own clinics throughout the country, and, as an MOH partner in reproductive health interventions, sometimes operates through (or provides contraceptive

[3] Vasectomy services are not offered in Guinean health facilities: Few providers are trained to provide this service, and demand for vasectomy is extremely low.

commodities to) public clinics. Much of the funding for this nonprofit organization originates from International Planned Parenthood Federation.

Other organizations working in the field of reproductive health in Guinea include EngenderHealth, Population Services International, Management Sciences for Health, the United Nations Population Fund, the U.S. Agency for International Development (USAID), KfW (a government-owned German development bank, originally Kreditanstalt für Wiederaufbau), Save the Children, the Adventist Development and Relief Agency International (ADRA), Family Health International, and the World Bank.

ACQUIRE's Three-Phase Program to Increase Guinean Women's Access to and Awareness of Long-Acting and Permanent Methods

In 2004, the ACQUIRE Project began a three-phase intervention in Guinea to increase women's access to and awareness of LAPMs, thereby increasing the range of methods available to women beyond hormonal methods and enabling them to better meet their needs to either space or limit future births.

Phase I

In the first phase of the project, ACQUIRE, in coordination with the PRISM project, worked with the Guinea MOH to conduct a performance needs assessment (PNA) to identify performance gaps in the provision of LAPMs and to determine the most appropriate interventions for improving providers' performance and clients' and communities' access to and use of LAPMs. The specific methods of interest included male and female sterilization, IUDs, and implants. From February 24 to March 9, 2004, 14 sites throughout Conakry, Kankan, and Faranah regions were assessed, and 32 providers and 34 clients at these sites were interviewed. Two meetings chaired by MOH officials were held with in-country stakeholders (including representatives from the MOH, USAID, AGBEF, and other nongovernmental collaborators) to establish desired provider performance targets, to engage stakeholders in a process of identifying root causes for performance gaps found, and to involve stakeholders in the identification of appropriate intervention strategies.

The PNA found a clear unmet need for family planning in both spacing and limiting subsequent births. Many of the family planning, postpartum, and antenatal care clients interviewed either wanted to wait a number of years before having more children, did not want any more children, or were not sure if they wanted more children. Despite this fact, only half of the clients interviewed reported having received information on family planning from the provider. Information received from providers primarily concerned temporary methods, and few clients were told about the IUD or about voluntary sterilization.

The following are reasons why clients do not learn more about LAPMs during consultations at the health facility:

- Providers tend to focus the family planning information they give to the client on the method she asks about, without first discussing the woman's reproductive goals, to learn more about her needs and to discuss how to address them.
- In general, providers miss opportunities to provide information on family planning. Among postpartum and antenatal clients, 85% (N=20) reported not being told about family planning methods during their visit.

The reasons for the gaps in the provision of LAPM information by providers were systemic. Providers had good attitudes regarding LAPMs: They spoke highly of LAPMs, but felt that clients had reservations about using them. The majority of providers appreciated the IUD in particular, mentioning that the method is "good," there is "no risk of forgetting," and it is long-acting, with an immediate return to fertility. Providers were not given clear expectations, however, regarding their role in service delivery and despite making frequent visits, supervisors did not reinforce with providers the need to discuss clients' reproductive goals and current situation or to discuss LAPMs, when appropriate. Also, information, education, and communication (IEC) materials used to discuss family planning with clients (such as flipcharts) tended to provide more information on temporary family planning methods than on LAPMs, perhaps leading providers to focus the client's attention on these methods. In addition, the study found that providers' work environment was not conducive to improved performance: Most of the providers interviewed reported electricity and water shortages and stock-outs of necessary supplies and materials.

Results from the PNA showed that the actual performance of family planning service providers in relation to LAPMs was low, resulting in large performance gaps. Stakeholders identified the root causes for the prioritized gaps and, based on their collective experience, brainstormed interventions for resolving these gaps. Among the priority interventions were the following:

Client-level interventions

- Develop and implement a promotional campaign to increase clients' information regarding LAPMs—e.g., radio spots, educational talks, and support groups
- Train community health agents to provide information in the community regarding LAPMs
- Conduct a community study to better understand opportunities for and barriers to the use of family planning methods in general and of LAPMs in particular

Provider-level interventions

- Update providers' knowledge of LAPMs—particularly female sterilization and vasectomy—to improve information sharing and counseling
- Update IEC materials to include more information regarding LAPMs
- Develop job aids to reinforce the family planning messages that providers should be giving

System-level interventions

- Make family planning and LAPMs priorities for the MOH and have them communicate this message to staff at the lower levels of the health system
- Strengthen the management of logistics and supplies to prevent stock-outs of necessary materials and tools within each health facility

These recommended interventions are reflected in activities undertaken as part of phases II and III of the project, as described below.

Phase II

The second phase consisted of a research project (in collaboration with Family Health International) to bring further clarity to supply and demand issues concerning family planning methods in Guinea and to identify community awareness of, and barriers to, LAPMs. Of particular interest was the IUD, which is highly effective (>99%) both as a long-acting and as a short-acting method (Trussell, 2004). The IUD has been found to have a high satisfaction rate among users (Forrest, 1996) and is a very cost-effective method for programs to offer (Chiou et al., 2003).

Qualitative data were collected in 2004 through interviews with key informants (religious, women's group, and community leaders, and providers) and focus-group discussions with women (ever-users and nonusers of modern contraception) and with men. Four communities—two urban and two rural—were chosen in the prefectures of Kankan and Siguiri in the region of Upper Guinea.

The study found that overall both men and women favored the notion of spacing births at least two to three years apart. The main benefit men perceived from this practice was the health of the child, but men also expressed fear that use of modern contraceptives would lead women to engage in promiscuous behavior. Women were generally more favorably inclined toward using contraceptives, and it appeared that many of them did so "*en cachette,*" or without their partner's knowledge. Strong cultural traditions, including polygyny and the perceived benefits of having many children (e.g., high child mortality rates, worries about who will care for aging parents, the need for help with agricultural chores, men's status in the community) limited the level of contraceptive use among respondents in Upper Guinea.

While respondents' attitudes toward birth spacing were generally favorable, the limiting of births was not condoned. The study found that actively terminating one's fertility was unacceptable as a voluntary choice, although it might be allowed in situations where a woman faced a difficult pregnancy or delivery.

The study found the prospects for introducing the IUD, a long-acting but not permanent method, to be quite positive. Women either knew very little about the method or had heard primarily positive things about it. The IUD also corresponds to the three characteristics women noted to be most important in terms of family planning methods: discreetness, minimal side effects, and an immediate return to fertility. Among both men and women, misconceptions about the IUD were common and were related to perceived negative health consequences to the woman and to children born to women who had used the IUD.

Women in particular cited health care workers as trusted sources of information about family planning and the IUD. These women indicated that if health care workers were well-trained and client-focused, women would be interested in learning more about whether the IUD would be an appropriate method to use. Some participants also noted that religious and community leaders should be included in educational programs concerning family planning methods because of their role as gatekeepers in the communities. According to respondents, religious leaders discuss family planning broadly at services and during private consultations, with discussions focused on the need to space births using breastfeeding and abstinence. In terms of media, participants recommended that rural radio be used to communicate messages about family planning.

Information obtained from the first two phases of the project provided the groundwork for the third phase—an intervention to increase awareness and use of the IUD among women who desire a long-acting method of contraception. Since the first two phases of the project have been described in detail elsewhere (The ACQUIRE Project, 2005; Escandon et al., 2006), the final phase of the project will be the focus of the remainder of this case study.

The Design of the IUD "Supply and Demand" Pilot Project in Upper Guinea

In February 2005, the ACQUIRE Project, in partnership with the MOH in Guinea, began a pilot intervention to raise community and client awareness of the IUD and to strengthen the capacity of MOH facilities to provide IUD services in Upper Guinea. The pilot used "supply and demand" interventions to increase awareness of and access to the IUD in Upper Guinea. For the purpose of this project, the term "supply and demand" refers to a combination of interventions that include health care provider training, provision of high-quality products, and development of tools such as job aids (the supply-side interventions), along with a variety of communication activities to inform key stakeholders and potential clients about what the IUD is, how the method works, what its benefits and contraindications are, and where to obtain IUD services (the demand-side interventions).

The district of Siguiri in Upper Guinea was identified as the focal point for the pilot supply-demand approach to promote IUD services. Upper Guinea is a USAID intervention zone, by way of the PRISM Project, which is designed to increase the use of family planning and maternal health services through training, community mobilization, and technical assistance to improve management and logistics (including contraceptive supply). ACQUIRE chose to work in Siguiri in particular because no IUD interventions were occurring in the district, and collaboration was sought with ADRA, an ACQUIRE partner conducting family planning activities in the area. In 2005, the total estimated population of the intervention area was 302,135 inhabitants, with a total of 75,533 married women of reproductive age.

The Supply-Side Intervention

ACQUIRE's primary inputs on the supply side consisted of training health care workers in the district's provincial hospital and in six of its 13 health centers in the areas of counseling, infection prevention, and IUD insertion and removal, to ensure that hospital and health center staff were prepared to counsel clients on the IUD and to correctly insert or remove the IUD. In addition, the whole-site training (WST) approach was used, whereby trainings are held onsite; needs are identified through self-assessment approaches, such as COPE (EngenderHealth, 2003); and instruction is supported by facilitative supervision. By training *teams* rather than individuals at the service-delivery site, the site is able to continue to effectively provide services when individuals are off-duty or on leave. Those who are trained are responsible for sharing their knowledge and skills and for training others, thereby sustaining the site (Bradley, 2000). In this way, efforts were made to involve all stakeholders in IUD revitalization efforts in Siguiri.

The Demand-Side Intervention

The demand side of the intervention consisted of three major types of activities: a communications campaign, outreach to religious leaders to create an enabling environment, and community mobilization activities.

The communications campaign was developed with technical assistance from ACQUIRE partner Meridian Group International, Inc. Creative, design, and production work was provided by Graphic

Concept (a local agency); and public relations, outreach, and coordination expertise was provided by the ACQUIRE manager in Guinea. A total in-country budget of $35,000 was allocated to the development, production, and dissemination of these activities. Based on the results of the qualitative research, the media channels used to reach the intended audience included print materials, rural radio, and interpersonal communication. These forms of communication were chosen based on cultural preferences for interpersonal and community-level communication channels, the specific geographic area involved, the limited budget available, and the lack of local capacity in advertising and communication services.

The audiences for the communications campaign were determined mainly through the qualitative research project conducted in Upper Guinea in 2004. The four audience segments identified were married women 25–40 years old, married men about 40 years old with multiple wives and numerous children, service providers, and religious leaders. To guide the campaign, four creative briefs were developed to address the four audience segments.

An initial set of campaign messages and materials emerged through insights gained during the qualitative research study. These materials underwent extensive pretesting to clarify and confirm the appropriateness of both the messages and their presentation. Materials were pretested in Mandiana, a district southeast of Siguiri, with the assistance of Save the Children. A total of six focus groups were held, with each of the following three target groups: married men, women of reproductive age, and religious leaders. In addition, nine service providers participated in individual interviews. The MOH was involved in the review of the materials throughout the process of their development—specifically, ministry officials reviewed the content of the messages to verify their congruence with MOH family planning policies and their general acceptability and appropriateness.

As a result of the pretesting, one of the major changes made was to replace an image of a male provider inserting the IUD with the image of a female provider wearing a white coat, since IUDs in the Guinean context most likely will be inserted by female health care providers. Additional changes included making the female client's clothing appear more 'traditional' (both in style and in the amount of the woman's skin revealed) and having the provider wear a glove in images showing the clinical examination and IUD insertion.

After the messages and materials were pretested, a final campaign theme was developed with the tag line "*Un contraceptif idéal pour espacer les naissances*" (an ideal contraceptive for spacing births). This theme was deemed appropriate since both the qualitative study and pretesting focus groups indicated that women will choose a birth-spacing method but not a method for limiting births.

Key benefits of the method were highlighted on all print materials and in radio messages: namely, that the IUD is effective and discreet, is easy to use, is a long-acting method, and has few side effects. Several rounds of revisions ensued from February to June 2006 based on audience feedback, communication and technical assistance from ACQUIRE/Meridian Group International, Inc., and medical expertise from ACQUIRE/EngenderHealth in New York.

Language issues were an important consideration in the development of this campaign. Radio and interpersonal channels used Mandingo, the predominant local language. Printed materials were written in French and in Mandingo, a local language with its own alphabet (N'ko) that is more easily understood by some segments of the population.

Print Materials

The print aspect of the communications campaign consisted of the following materials:

1. A consumer brochure (Appendix 1)
2. A poster listing sites offering the IUD (Appendix 2)
3. A poster featuring a traditional Muslim family with three children (Appendix 3)
4. A poster featuring a relatively affluent family with two children (Appendix 4)
5. A poster featuring a woman, with the tag line reading "An ideal contraceptive for the ideal woman" and a testimonial quote verifying that she has used the IUD for two years without any problems (Appendix 5)

Two additional print materials were developed in support of clinical training activities: (1) a poster to be displayed at the clinic with reminders about key counseling points (Appendix 6), and (2) a job aid in the form of a brochure, "What health workers need to know" (Appendix 7), which summarized the IUD's mechanism of action, eligibility criteria, and side effects and included reminders about counseling and service-delivery issues.

Rural Radio "Satisfied Client" Testimony

Hadja Mariama Diare, 45 years old, is in a polygamous marriage. She was previously married and has three children (two from her first marriage). She is wealthy and owns a big shop and a Mercedes. She is well known within her community. When she learned about the ACQUIRE Project and the availability of IUDs, she volunteered to share her experience with an IUD she had had inserted in 1996, almost 10 years ago.

Hadja Mariama Diare recalled that after experiencing a very difficult delivery, she decided to use a family planning method. She started using Depo-Provera, but experienced some side effects, so she decided to use the IUD. "At the time, I was skeptical about the method" she recalled. "But as I have been regularly counseled by my friend, I kept it and had to replace it only once."

Hadja Mariama Diare had a few problems with the IUD. Her husband was uncomfortable with the strings. She said that "all problems related to the IUD are in women's heads. They have misconceptions and myths regarding the IUD. Some women said that they experienced dysmenorrhea with the IUD, but I did not."

After four years of using the IUD, she decided to have a child. She had the IUD removed and became pregnant three months later. She is now 45 years old and no longer uses an IUD, as she is in menopause.

In conclusion, Hadja Mariama Diare said, "I would strongly recommend the IUD to women as a simple, long-lasting, discreet, and affordable family planning method." An IUD costs 1,000 Guinean francs.

Meeting of Religious Leaders

In March 2006, ACQUIRE convened a two-day meeting of religious leaders in Siguiri, in collaboration with the League of Islamic Affairs and the Siguiri District health officials. Participants included four national-level members of the League of Islamic Affairs, three representatives of the Kankan Region, and two representatives from every subdistrict in Siguiri. In addition, 36 members of the Islamic Women's Association of Siguiri were involved in the meeting, which was facilitated by Elhadj Fadiga, Minister of Islamic Affairs.

A primary objective of this meeting was to present information to the religious leaders about the benefits of family planning methods, including long-acting methods such as the IUD, so that they would serve as champions of the campaign. Participants received the customer brochure at the meeting as an additional source of information. This dialogue aimed to create an enabling environment that would facilitate sharing information about the IUD to married couples through radio, print, and direct communication. The meeting received coverage on the local radio.

Rural Radio

During January through October 2006, a series of radio programs helped to set the stage for the communications campaign. Through various talk show formats, such as roundtables and question-and-answer programs featuring a variety of perspectives (physicians, religious and community leaders, and women who had successfully used the IUD), the community was informed about the IUD, its benefits, and various myths and rumors associated with it. Broadcast in the local language of Mandingo, these programs alternated between "micro-programs" (five minutes daily), which highlighted the IUD's benefits and directed clients to specific health centers for additional information, and "magazine programs," which are 20 minutes in duration and allow for detailed dissemination of messages (such as imams stating their commitment to and support of the use of modern family planning methods. The primary audience of this aspect of the campaign was married couples.

Community Mobilization Using the Participatory Learning Approach

This campaign placed special emphasis on leveraging radio and print efforts by linking to strong community structures. Communities were engaged in dialogue through a Participatory Learning Approach (PLA), which was offered through the technical assistance of ACQUIRE partner CARE to the Adventist Relief Agency International (ADRA). ADRA brought to the ACQUIRE Project strong community mobilization experience in Siguiri and already had links to village-level health workers and health committees. Their "*animateurs*," or community mobilizers, were trained in the PLA process by CARE with the specific objective of promoting modern family planning methods such as the IUD within village structures and channels. These communities received copies of the print materials; developed appropriate community organizations such as women's groups, or *sérés*; and were engaged to disseminate and reinforce messages promoting awareness about the IUD. A total of 72 communities were involved in the PLA activities.

Outputs and Outcomes of the IUD Pilot Intervention in Upper Guinea

The study's monitoring and evaluation activities included developing indicators to monitor project results (see Appendix 8), refining tracking and reporting mechanisms for service-delivery statistics, and designing and implementing a client intake form to assess exposure to and recall of campaign messages among clients of each of the seven targeted health facilities.

A local ACQUIRE consultant collected service statistic data (including data on all methods obtained, IUD removals and check-ups, and method stock-outs) from each of the seven facilities on a biweekly basis. The form used to collect these data paralleled MOH data collection forms but included more detailed information about IUD insertion and removal. Each month, the consultant delivered a separate form with aggregated data for each facility to both the ACQUIRE office in Conakry and MOH officials at the prefectoral (local) level. The data were discussed with the MOH and the providers to help identify and address any challenges experienced (e.g., stock-outs experienced at any of the facilities).

The client intake form was administered to male and female clients at the seven health care facilities from July through September 2006 by six trained medical student interviewers. At each facility, every third female client and every male client were interviewed. The intake form was administered one day each month, based on the health center's busiest hours of the day. A total of 731 clients at the seven facilities completed intake forms; 93% of these clients were female. Key results are described under "Demand for the IUD" below. (See appendixes 10 and 11 for complete results of the intake forms, including client demographic information.)

More than half (53%) of the women surveyed and 43% of the men surveyed were family planning clients; the remainder of the clients were visiting the facilities for other medical issues. Data analysis was conducted using EpiInfo and SAS. Differences between those seeking IUD services and those seeking other services were identified using chi-square statistics or Fisher's exact test when expected cell counts were less than five for categorical variables; the t-test was used for continuous variables. Statistically significant differences between sexes were not assessed due to the drastically discrepant sizes of the two groups.

Project Outputs

IUD Supply

A total of three ACQUIRE-supported training events were held (Table 1) between May and December 2005. Two whole-site training sessions were held at the Siguiri District Hospital; the first training included family planning providers from each of the seven facilities, and the second was held for other staff, including administrators and support staff. These trainings included a contraceptive technology update and infection prevention training. One IUD insertion and removal training was held for two providers from each site (with the exception of providers from the district hospital, who had been previously trained by EngenderHealth under a subcontract with PRISM).

Table 1: Training statistics

Primary Training Category	Number of training events	Number of persons trained	Male	Female
Whole-site training (WST): Contraceptive technology update (CTU)/infection prevention (IP)	1	28	12	16
WST: CTU/IP	1	22	9	13
IUD insertion/removal	1	12	7	5
Total trained		**59**	**26**	**33**

Two ACQUIRE senior medical advisors conducted two site visits at each site to ensure performance improvement. The first site visits were in May 2006 and the second were in September 2006. These medical advisors assessed provider performance during counseling sessions and during IUD insertions and removals using family planning checklists developed by the MOH. These assessments showed that all providers were meeting the required performance score of 80%.

With the exception of Siguiri Koura and the maternity of Siguiri District Hospital, which experienced stock-outs in January, April, July, and October 2006, all seven facilities provided IUD services throughout the course of the project. The IUDs were to be supplied by the MOH. Siguiri Koura and the district hospital's maternity were unable to secure sufficient commodities: this can be partly explained by the fact that the facilities did not order a sufficient quantity of IUDs initially, and later were unable to obtain them from the MOH due to a stock-out in the regional warehouse of the Guinea Central Pharmacy. Upon learning of this issue, ACQUIRE communicated with the MOH to facilitate the supply of IUDs to the facilities.

Demand for the IUD

The radio program started in January 2006 and ended in October 2006. During this time, 62 "microprograms," three roundtables, 10 magazine programs, and three testimonies from satisfied clients were aired.

Beginning in April 2006, community motivators and ACQUIRE's consultant disseminated 2,747 consumer brochures and 496 posters at the community level and through health care delivery sites (196 and 300 posters, respectively). All seven of the ACQUIRE-supported facilities received new communications materials on the IUD.

Between January and October 2006, a total of 36 communities were selected to engage in participatory learning and action activities, and 18 of these communities developed their own community action plans (six communities in Siguiri town and in Doko, and three communities in Franwalia and in Kintinina); approximately 180 women and 184 men were engaged in this process. Of the 18 community groups that developed community action plans, 12 (65%) completed at least two tasks identified in the action plans. Tasks identified included (1) providing accurate information about IUD use (to correct rumors and misinformation), (2) directing people to the sites that provide IUD services, and (3) highlighting the benefits of using the IUD. In addition, 10 women's groups, or *sérés*, were involved in educational activities about the IUD.

Community motivators' records showed that almost 12,000 people were reached through IUD sensitization and information dissemination activities, as developed in the action plans (Table 2). More than half of the sensitization activities occurred within the health facilities, though a large number of individuals were reached through activities outside the facility (e.g., at community gatherings, at baptisms, at marriage ceremonies, and by one-on-one communication, such as through home visits). Men comprised almost one-fifth (18%) of those reached by community sensitization activities.

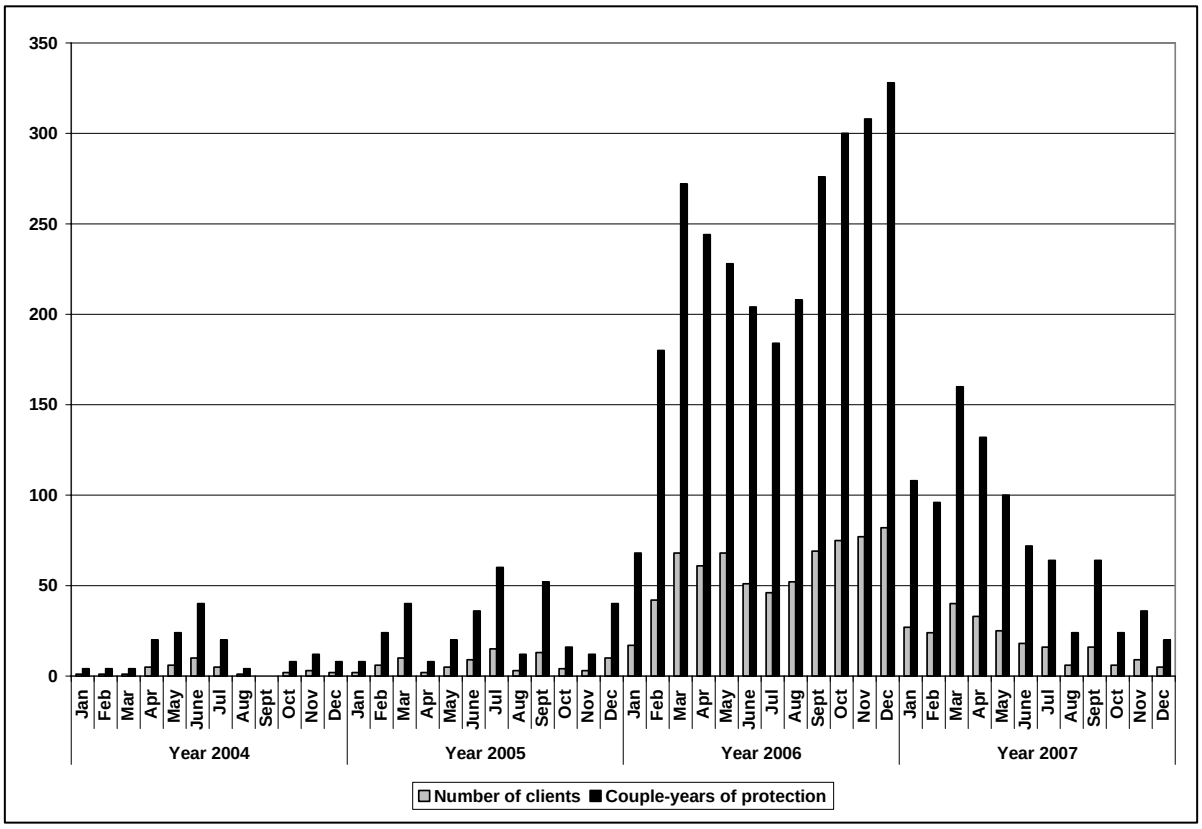
Table 2: Sensitization activities

	Number of activities	Men	Women	Total population reached
Within health facility	313	1,425	5,045	6,470
Outside health facility	179	647	2,035	2,682
Individual interview/home visits	2,478	101	2,723	2,824
Total	2,970	2,173	9,803	11,976

Project Outcomes

As illustrated in Figure 1, facility records showed that 700 new IUD users were served in ACQUIRE-supported facilities during the interventions in 2006, compared with only 37 clients in 2004 and 82 clients in 2005—the years preceding the intervention. During the period 2004–2006, the number of users of other contraceptive methods, such as Depo-Provera and oral contraceptives, remained almost static. The corresponding annual number of couple-years of protection (CYP) provided by the IUD (calculated as 3.5 CYP per IUD inserted) increased from 130 and 287 in 2004 and 2005, respectively, to 2,450 in 2006. Monthly CYP trends are illustrated in Figure 1. The decrease in CYP in the first half of 2006 may be attributed in part to the IUD stock-outs mentioned above. Notably, there were 225 new IUD users at the seven facilities in 2007, the year following the active project period. While these figures represent a decrease from the number of new users at these facilities in 2006, they remain considerably higher than the figures at those facilities in the two years preceding the intervention.

Figure 1: **Number of new IUD clients and IUD CYP, 2004–2006**
(*Note:* Communications campaign were implemented in the period January–October 2006)



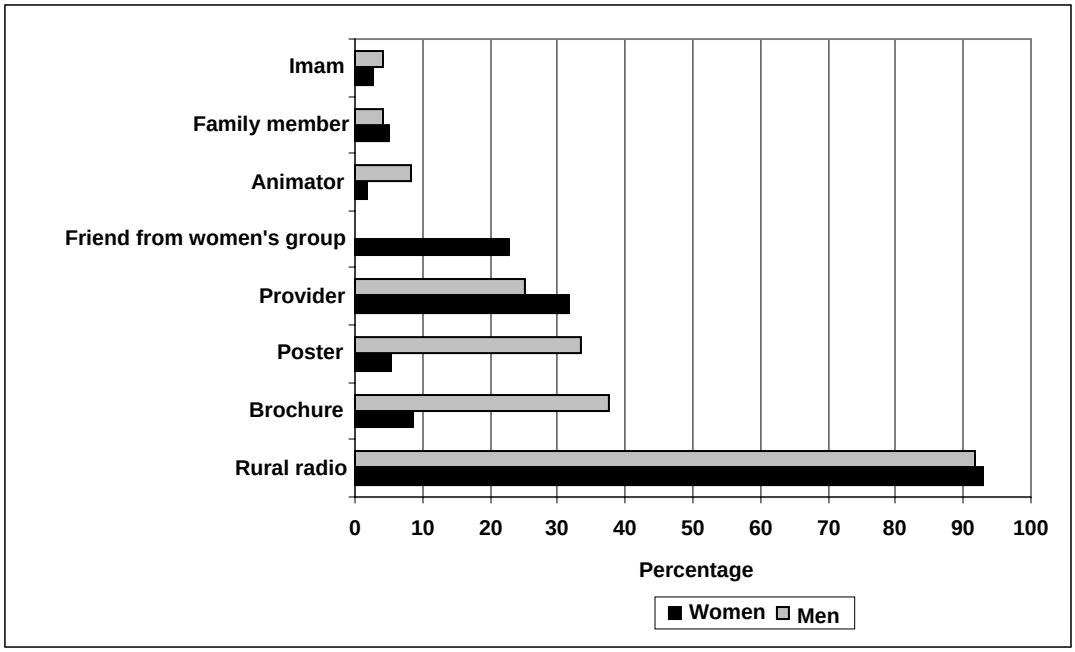
As described above, client intake interviews were administered to male (N=49) and female (N=682) clients at the seven ACQUIRE-supported sites (N=731); this sample included both family planning clients and clients seeking other health care services. Almost half of the men (49%) interviewed and the majority of women interviewed (82%) had heard of the IUD (see Appendix 10).

As shown in Figure 2, among clients who had heard of the IUD, the most common source of information about the method was rural radio, as reported by 93% of women and 92% of men. Although it cannot be ascertained that clients had only heard ACQUIRE-sponsored messages regarding the IUD on rural radio, half of the participants (49% of women and 63% of men) surveyed reported having heard the ACQUIRE-sponsored imam roundtable (see Appendix 10), indicating that ACQUIRE-supported radio programming about the IUD was indeed a significant source of information.

The next most commonly cited source of IUD information was a health care provider, as reported by between one-quarter and one-third of those surveyed (32% of women and 25% of men). More than one-fifth of the women surveyed reported receiving information about the IUD from a friend in a women's group (23%). Fewer than 10% of participants overall reported receiving information from a brochure or from a poster, with exposure to these print sources more frequently reported among men: Thirty-three percent of men reported receiving information from a poster, compared with 5% of women, and 38% of men reported receiving information from a brochure, compared with 9% of women. Only a small percentage of the overall sample received information about the IUD from a family member (5%), from an imam (3%), or from a community motivator (2%).

When asked to respond freely regarding the principal messages they recalled about the IUD, 92% of the women and 87% of the men surveyed at the seven facilities accurately recalled at least one message from the IUD media campaign. Among men, the method's reversibility, effectiveness, and affordability were the messages most frequently recalled (38%, 33%, and 29%, respectively). The most salient message for women, with 42% recall, appeared to be that the IUD is long acting. More than one-quarter (27%) of women recalled that the IUD is effective, and one-quarter (26%) recalled that it is discreet and reversible.

Figure 2: Sources of information about the IUD, by sex



The study conducted further analyses to compare women seeking IUD services (either IUD information or the method itself) to women seeking other family planning services (see Appendix 11). A total of 166 (51%) women seeking family planning services sought IUD services in particular. Women seeking IUD services were significantly less likely to report wanting children "this year" (3% vs. 31%, *p*-value<.05) and were significantly more likely to be currently using family planning methods (71% vs. 58%, *p*-value<.05).

Women seeking IUD services were equally likely to have heard of the IUD as were women seeking other family planning services; however, women seeking IUD services were significantly more likely to have received information about the IUD from a friend in a women's group (37% vs. 15%, *p*-value<.05), to have received information from a community motivator (6% vs. 0%, *p*-value<.05), and to have received information about the IUD from a brochure (18% vs. 5%, *p*-value<.05). Women seeking IUD services were also significantly more likely than were women seeking other family planning services to report having heard the imam roundtable on the radio (64% vs. 47%, *p*-value<.05); however, women seeking IUD services were less likely to report receiving information about the IUD from the radio than were women seeking other family planning services (90% vs. 97%, *p*-value<.05).

Women seeking the IUD were marginally more likely to recall at least one message from the IUD campaign (92% vs. 86%) and were significantly more likely to recall the specific message that the IUD is effective (35% vs. 15%, *p*-value<.05).

In summary, though limitations on financial and technical resources (both in-country and via international technical assistance) precluded the implementation of a larger scale project evaluation, the service statistics and client intake results from the pilot IUD intervention in Guinea indicate that the ACQUIRE communications campaign to promote IUD awareness and knowledge, coupled with improvements in IUD supply, succeeded in attracting a large number of new clients to the IUD.

Conclusions, Lessons Learned, and Recommendations

This case study illustrates the short-term effectiveness of a multipronged strategy to revitalize a family planning method in a low-resource setting. This campaign was implemented with minimal monetary investment, in a context with little local marketing capacity, limited media, and a relatively conservative religious culture. Nonetheless, the dedicated efforts of many providers, community volunteers, and others resulted in a substantial increase in IUD use during the period from the beginning of the demand-generation campaign (January 2006) to two months after it ended (December 2006). Seven hundred clients chose the IUD at ACQUIRE-supported facilities—an almost ninefold increase compared with the previous year (2005), and a 19-fold increase compared with 2004. During this period, the number of users of other methods, such as Depo-Provera and oral contraceptives, remained almost static.

Rural radio proved to be an extremely effective method of exposing both men and women to information about the IUD, although among women, providers and *sérés* were also commonly reported sources of information. Women seeking IUD services were significantly more likely than women seeking other family planning services to learn about the method from a friend in a *séré*, from a community motivator, or from a brochure, suggesting that these sources were particularly influential in affecting a woman's decision to seek IUD services and that social influence may play an especially important role in decision making. Women seeking IUD services were also significantly more likely to report having heard the imam roundtable on the radio, suggesting that the involvement of religious leaders in campaign messages may have played an important role in women's decisions.

Evidence from this case study suggests that to achieve wider contraceptive coverage and expand the reproductive health choices of women throughout Guinea, the communications campaign should be scaled up to other underserved regions, in concert with supply-side interventions and engagement of religious leaders and district MOH officials. The following insights, lessons, and recommendations should be considered as future efforts are planned and implemented.

Program Insights

1. **Seek stakeholder involvement early in the process.**
   Interventions must be tailored to suit the specific context in which one is implementing a program; therefore, *early stakeholder involvement* is important to identify the specific needs of a community and to ensure that interventions are targeted accordingly. This involvement can come in the form of stakeholder meetings or PNAs to discuss the problems and prioritize the issues that the program can address. Key community gatekeepers, such as community leaders or religious figures and district MOH officials, should be brought in early with to provide input to and support for the initiatives.
2. **Assess community attitudes before creating communications materials.**
   Assessing community attitudes and barriers that impede the utilization of LAPMs is necessary if a communications campaign is going to effective target these barriers. In Guinea, this was achieved by conducting a qualitative assessment of attitudes toward LAPMs. While resources may not always be available for in-depth assessments or studies, smaller scale focus-group discussions also can provide critical insight into community attitudes. Community attitudes must be ascertained before a communications campaign is developed.

3. **Solicit stakeholder input and pretest campaign messages before finalizing communications efforts.**
   Stakeholders such as community volunteers can provide valuable insights into campaign materials, and involving them in the development process will help foster ownership of those materials. Pretesting campaign messages and materials will help identify which messages are most appropriate and accepted by both stakeholders and the community. In this initiative, pretesting the print materials yielded invaluable insights from members of the target audience. Pretest results led to a number of wording and graphics changes that ultimately strengthened the impact of the messages.
4. **Involve religious leaders to help create a favorable environment for communications campaigns.**
   The IUD campaign's outreach efforts with Muslim leaders, particularly the roundtables with imams that were aired on rural radio, may have played an important role in disseminating messages about the IUD and in promoting the acceptability of the method. Data from client interviews showed that women seeking IUD services were significantly more likely than women seeking other family planning services to report having heard the imam roundtable on the radio.

Lessons Learned

1. **Rural radio is an effective way of disseminating family planning information in a low-resource setting, while interpersonal communications efforts can simultaneously strengthen the effectiveness of communication messages.**
   Among the men and women who reported having heard of the IUD, 45% of men and 76% of women said they heard about it through rural radio. Overall, rural radio was the most common source of information about the IUD. Interpersonal communication and peer influence also played important roles in increasing knowledge about the IUD; results from client intake interviews showed that women seeking IUD services were significantly more likely than women seeking other family planning services to have received information about the IUD from a friend in a *séré*.
2. **A targeted communications campaign conducted in a low-resource setting with short bursts of advertising and promotion can be extremely effective.**
   The Guinea IUD experience demonstrates that dramatic increases in method use can occur when well-targeted, relevant messages are disseminated with a minimal communications budget. As many as 700 new IUD users were served in ACQUIRE-supported facilities during the communications campaign in 2006, compared with 82 in 2005 and 37 in 2004.

Recommendations

1. **There must be a steady supply of commodities and enough trained providers before communications activities that aim to increase awareness of and knowledge about the IUD are implemented.**
   Because of stock-outs, two of the health facilities were unable to adequately satisfy client demand. Prior to the implementation of demand-generation activities, it is necessary to coordinate with the MOH to ensure that there is a steady supply of commodities and that facilities have a mechanism to secure additional supplies in a timely manner, if necessary.
2. **Short bursts of advertising and promotion have limited impact in the long term; communications activities should be sustained for long-range impact.**
   Short-term communications campaigns have a short-term impact. The number of new IUD users at the seven targeted facilities declined from 700 during the active project phase in 2006 to 225 in the year following the project (2007). Audiences need to receive messages multiple times,

through various channels, if knowledge, attitudes, and practices are to be shifted to a sustained level of behavior change. Nonetheless, the 2007 levels of IUD acceptance were still much higher than those in the preintervention phase, pointing to a possible residual effect of the campaign.

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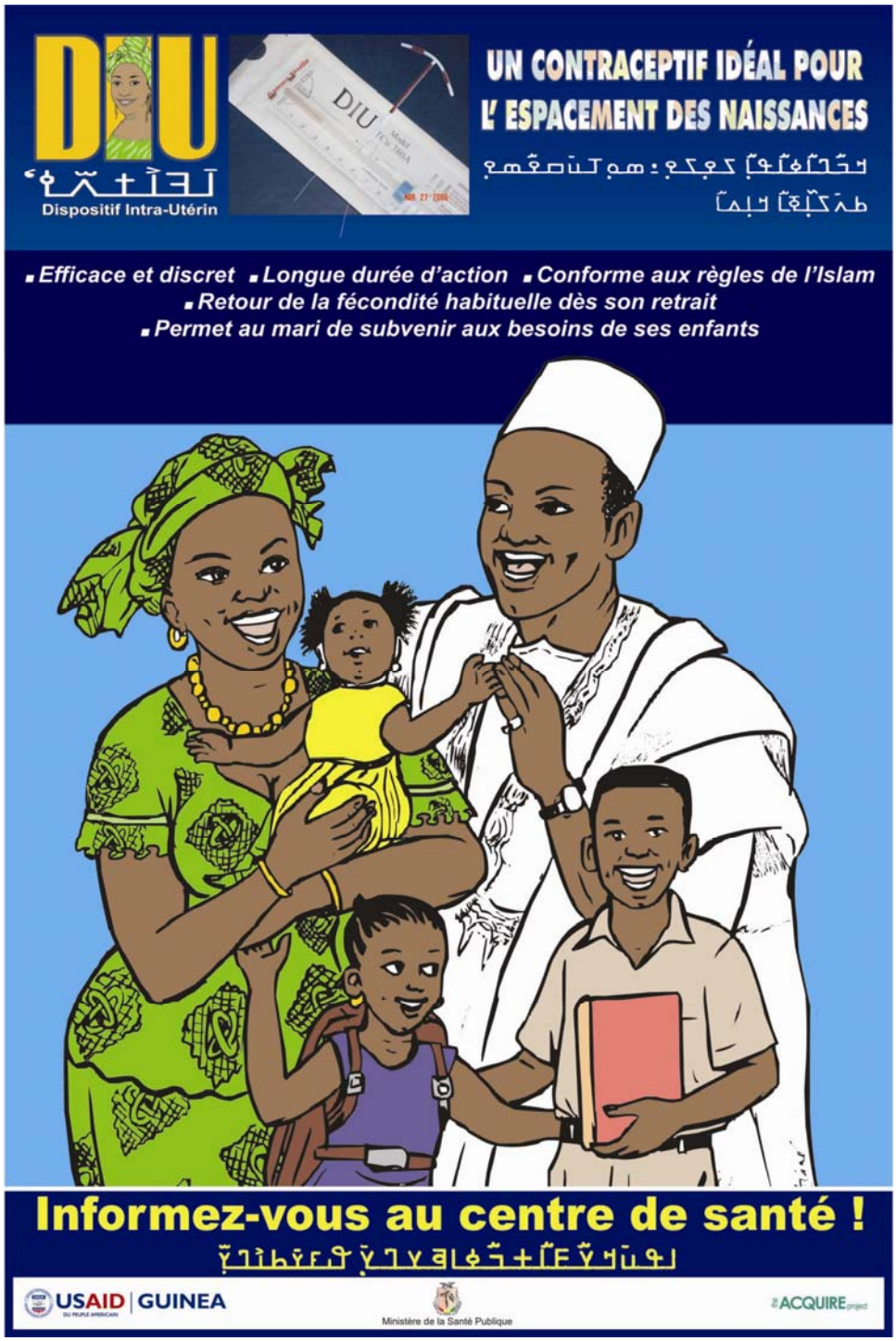
Appendix 1:
Consumer Brochure

Appendix 2:
Poster Listing Sites Offering the IUD

Appendix 3:
Poster Featuring a Traditional Muslim Family with Three Children



Appendix 4:
Poster Featuring a Relatively Affluent Family with Two Children

Appendix 5:
Poster Featuring the Testimonial of a Satisfied Client

Appendix 6: Clinic Poster

Appendix 7:
Provider Job Aid

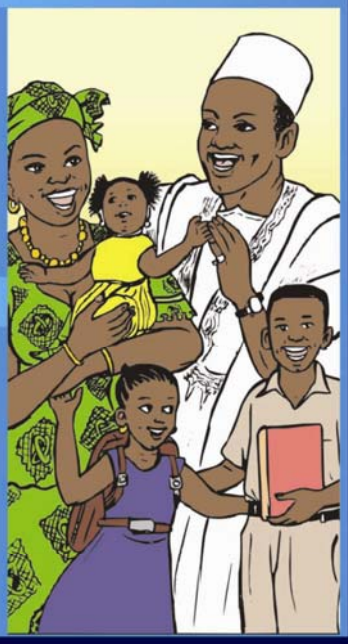
Side I

Side 2

Avantages

Toute femme qui se présente au centre de santé choisira le DIU à cause de :

- son efficacité contraceptive
- sa discrétion
- sa durée d'action
- ses rares effets secondaires
- la rapidité du retour de la fertilité
- la spontanéité de l'acte sexuel



Effets secondaires

Toute femme porteuse du DIU :

- peut avoir des petites douleurs au moment de l'insertion
- peut avoir des règles douloureuses pendant les premiers mois
- peut expulser son DIU si elle tire sur le fil
- peut avoir des règles prolongées

Rôle de l'agent de santé

L'Agent de santé qui pose et retire le DIU doit toujours :

- Etre formé à cet effet
- Bien recevoir les clientes venant au centre de santé pour la planification familiale
- Expliquer toutes les méthodes de PF disponibles et laisser la cliente choisir sa méthode
- Expliquer sur les avantages si la cliente choisit le DIU
- Faire un examen clinique et gynécologique complet
- Placer le DUI en respectant les principes de la prévention des infections
- Prodiguer des conseils avant toute pose ou retrait du DIU
- Suivre ses clientes en cas d'inquiétude ou de problèmes
- Prévenir la cliente des possibles effets indésirables tels que les douleurs au bas-ventre, les pertes vaginales et la disparition des fils.
- Demander à la cliente de revenir vous voir à chaque fois qu'elle a des problèmes (même en dehors des rendez-vous)
- Informer la cliente que le DIU ne protège pas contre les IST et le VIH/SIDA

Appendix 8:
Indicators Used to Evaluate Supply and Demand Campaign

Indicators	Description	Computation	Data source and data collection method	Time period/ frequency	Data use	Assumptions
SO1: Increased access to reproductive health/family planning (RH/FP) services						
FP method mix	Method mix refers to the number of users (or acceptors) by method	Count of the number of users (or acceptors) by method	Facility statistics; monitoring visit and review of facility statistics	Quarterly	USAID/W reporting	
Couple-years of protection (CYP), by method	Estimated protection provided by FP services during a one- year period, based on the volume of all contraceptives sold or distributed free of charge to clients	Multiplication of the quantity of each method distributed by the method-specific conversion factor	Facility statistics; Monitoring visit and review of facility statistics	Quarterly	USAID Guinea Mission	
Number of new users of IUD at project sites	Total number of clients receiving IUD insertions. This could include both clients for whom the IUD is the first method they are using and clients who are switching to the IUD.	Count of the number of acceptors by method	Service statistics	Quarterly	USAID/W reporting	The quality of this indicator depends on the quality of service statistics and on the site's compliance in submitting statistics
Number/ percentage of facilities without nonmedical restrictive eligibility criteria for the IUD	Such criteria could include requirements such as spousal consent or multiple visits. Other aspects are to be decided.	Division of the number of ACQUIRE-supported health facilities that have policies allowing full access to the focus method by the number of ACQUIRE-supported health facilities, then multiplied by 100	Project documents, interviews, and document review	Baseline and endline	USAID/W reporting	Follow-up can be carried out during monitoring visits as well.
Number of ACQUIRE-supported service sites providing IUD services	Number of health facilities supported by ACQUIRE that provide IUD services	Count of the number of ACQUIRE-supported facilities offering the IUD	Project records, facility assessments (as needed)	Baseline and endline	USAID/W reporting	

Indicators	Description	Computation	Data source and data collection method	Time period/ frequency	Data use	Assumptions
Support to national norms, standards, and guidelines	Support is defined as technical or financial assistance to design, update, or distribute norms, standards, and guidelines at national, regional, or district levels.	Qualitative indicator	Annual questionnaire from ACQUIRE/HQ to field	Annually	USAID/W reporting	
Support to reduce barriers to RH/FP services	Support is defined as technical or financial assistance to reduce barriers to any RH/FP service. (Barriers include unnecessary formal program policies, regulations, and procedures that restrict access to RH/FP services.)	Qualitative indicator	Annual questionnaire from ACQUIRE/HQ to field	Annually	USAID/W reporting	
1.1— Increased availability of RH/FP services at sites						
Number of training events held, by primary training type and cadre, per ACQUIRE-supported site	Training events can include training-of-trainer workshops, sensitizations, orientations, contraceptive updates, and whole-site training.	Count of the number of training events	Training reports	Collect as events occur and report annually	USAID/W and USAID/Guinea reporting	
Number of persons trained, by primary training type, cadre, and gender	*Type of training* can include IUD insertion, infection prevention, and community sensitization and awareness training *Cadre* may include surgeon, nurse, and counselor	Count of number of persons trained, by primary training type, cadre of service provider, and sex	Training reports/review of training reports	Collect as events occur and report annually	Reporting to USAID/W and USAID/Guinea	
SO2: Increased quality of RH/FP services						
2.1— Increased provider support systems						
Percentage of IUD sites where providers use job aids during client interaction	Job aids include flipcharts and other materials designed to improve client-provider interaction.	Number of sites where providers are observed to use job aids during client interaction, divided by the total number of ACQUIRE-supported sites	Medical monitoring visit	Pre-intervention and every six months	Program purposes	

Indicators	Description	Computation	Data source and data collection method	Time period/ frequency	Data use	Assumptions
SO3: Increased demand for RH/FP services						
Percentage of health facility clients reporting exposure to an element of the ACQUIRE IUD demand-side intervention, by type of exposure/element	Type of exposure includes radio (microprograms and roundtables), poster/brochure, and women's groups (*sérés*).	Number of FP clients reporting exposure to element of demand-side intervention, divided by the total number of FP clients interviewed at the facility.	Clinic intake form/exit interview/clinic intake form/ exit interview review	Quarterly	Program purposes	
Percentage of health facility clients accurately recalling at least one message from IUD IEC/BCC campaign	Messages may include the following: ♦ IUD has few side effects ♦ IUD is inexpensive ♦ IUD is effective ♦ Using the IUD does not impact fertility	Number of FP clients adequately recalling at least one message from demand-side intervention divided by total number of FP clients interviewed at clinic	Clinic intake form/exit interview/clinic intake form/exit interview review	Quarterly	Program purposes	
Number of communication materials developed	Includes brochures, posters, and pamphlets that have been developed in direct connection to the project intervention	Count of number of communication materials developed	Program activity report	Annually		
Number of program months demand campaign/program was implemented	Number of months that the communications campaign and/or community mobilization program was implemented with adequate exposure. Adequate exposure is defined as reaching workplan benchmarks.		Media plan and transmission reports	Annually		
Number/ percentage of clinics with new communication materials on the IUD	This indicator looks at the number/ percentage of clinics that have new brochures, posters, and pamphlets on the focus method.	(Number of ACQUIRE-supported health facilities that have posters displayed on the focus method divided by the number of ACQUIRE-supported health facilities surveyed, then multiplied by 100	Medical monitoring	Quarterly	USAID/W reporting	The frequency would be determined by the implementing agency; historically, the frequency in many EngenderHealth-supported countries has been quarterly. This indicator can be included in monitoring checklists.

Indicators	Description	Computation	Data source and data collection method	Time period/ frequency	Data use	Assumptions
3.1—Services promoted among target populations						
Percentage of community groups that have completed a problem identification, prioritization, and problem-solving process, including action plan development	Community groups engaging in PLA activities include women's and men's associations, religious bodies, and other important community entities that meet regularly. A total of 72 groups are participating in these activities.	Number of communities completing mobilization process through action plan development divided by the total number of community groups.	Program activity report	Quarterly	USAID/W reporting	
Number/percentage of community groups in which at least two tasks identified in action plans are carried out	Any community group that has worked to address one of the action plan items will be included, regardless of the outcome or the task. Tasks in process and tasks completed will be considered in this indicator.	Number of community groups carrying out at least two tasks divided by the total number of community groups.	Program activity report	Quarterly	USAID/W reporting	
Number of women's groups involved in IUD promotion activities	Women's groups (*sérés*) will take part in IUD promotion by discussing IUD and distributing IEC/BCC materials during their monthly meetings	Total number of *sérés* discussing IUD and distributing IEC/BCC materials during their monthly meetings	Activity report/activity report review	Quarterly	Program purposes	
Number of times a radio spot on the IUD is aired	The number of times during a set period of time that a radio program on the focus method is aired	Count of the number of times a radio program is played on the radio. (including on microprograms and roundtables)	Monitoring radio log	Quarterly	USAID/W reporting	
Number of people reached through IUD IEC/BCC communications activities and/or community mobilization events, by type	People reached are target audience members. The type of event would depend on the action plan developed. Figures will be estimates and will vary across countries.	Report by type of activity or event, and, if possible, by sex	Program activity report	Quarterly	USAID/W reporting	The type of event would depend on the action plan developed

Appendix 9:
Client Intake Form

Instructions: *À chaque cliente qui entre pour des services de planification familiale, veuillez dire ce qui suit:*

« Pour améliorer la qualité de nos services, votre avis est indispensable. Nous vous prions donc de nous accorder quelques minutes d'entretien avec vous. Notre entretien sera confidentiel et vos déclarations seront strictement confidentielles et votre nom ne sera pas cité. Si vous étés d'accord nous commençons».

Structure: _____	**Enquêteur:**	**Date:** /__/__/ /__/__/ /__/__/ Mois Jour Année	**Sexe du client** Male Femelle
1. Où habitez-vous ?		**2. Quel age avez-vous?**	
3. Avez vous des enfants ? (encerclez un): a. Oui →*si "oui", allez à la question 4* b. Non →*si "non", passez à la question 5*		**4. Combien d'enfants vivants avez-vous?**	
5. Comptez-vous avoir des enfants dans l'avenir? a. Oui → *si "oui", allez à la question 6* b. Non →*si "non", passez à la question 7*		**6. Dans combien de temps voulez-vous avoir un enfant?** a. Cette année b. 1-2 ans c. Après 3 ans et plus	
7. Présentement, utilisez-vous une méthode de planification familiale ? a. Oui →*si "oui", allez à la question 8* b. Non →*si "non", passez à la question 9*		**8. Quelle méthode de planification familiale utilisez-vous actuellement ?**	
9. Quelle est la raison de votre visite aujourd'hui ? (*Demandez la cliente de répondre à chacune des réponses ci après et encercler les réponses affirmatives)* a. Visite non-planification familiale b. Désir les informations générales sur la planification familiale c. Désir les informations sur une méthode PF particulière (**si oui, quelle méthode**:_____) d. Recevoir une méthode de PF pour la première fois, ou la première fois a cette structure sanitaire (**si oui, quelle méthode** :_____) e. Désir changer de méthode de planification familiale pour une nouvelle méthode (**si oui, quelle nouvelle méthode: _____**) f. Revient pour le suivi PF ou pour vous approvisionner en contraceptifs g. Autre (spécifiez)_____ → *Si le client mentionne le DIU, passez à la question 10* → *Si le client ne mentionne pas le DIU, passez à la question 11*		**10. De quelle source avez-vous eu connaissance de services DIU ici ?** (*Demandez la cliente de répondre a chacune de sources ci après et encercler les réponses affirmatives* A. Radio rurale B. Affiches C. Dépliants D. Amie du séré E. Agent de sante F. Animateurs / Distributeur a base communautaire G. Famille et parents H. Autre (spécifiez) _____ → *Passez à la question 12*	
11. Avez-vous déjà entendu parler du DIU ? a. Oui *(si "oui", allez à la question 12)* b. Non *(si "non", remerciez la cliente pour sa participation et arrêtez l'interview)*		**12. De quelle source avez-vous entendu parler du DIU les six derniers mois ?** (*Demandez la cliente de répondre <u>librement.)</u>* A. Radio rurale B. Affiches C. Dépliants D. Amie du séré E. Imams F. Agent de sante G. Animateurs / Distributeur a base communautaire H. Famille et parents I. Autre (spécifiez) _____	
13. Avez-vous entendu un Imam parler de la DIU à la radio rurale de Siguiri ? a. Oui b. Non		**14. Quels sont les messages principaux que vous avez retenus sur le DIU ?** (*demandez la cliente de <u>répondre librement</u>)*	

Appendix 10: Client Intake Data, by Sex

	Total		Female		Male	
	N	%	N	%	N	%
Total	**731**	**100**	**682**	**100**	**49**	**100**
Age	28.1	6.9	27.7	6.6	33.6	8.5
Has Children						
No	81	11.1	77	11.3	4	8.2
Yes	649	88.9	604	88.7	45	91.8
Mean No. of Children	3.9	2.3	3.7	2.2	5.3	2.8
Wants Children						
No	106	14.5	100	14.7	6	12.2
Yes	625	85.5	582	85.3	43	87.8
Desired Spacing of Children						
This year	174	28.2	158	27.5	16	37.2
1–2 years	208	33.7	189	32.9	19	44.2
After 3 years	236	38.2	228	39.7	8	18.6
Family Planning User						
No	454	62.3	435	64.0	19	38.8
Yes	275	37.7	245	36.0	30	61.2
Current Method of Family Planning						
IUD	33	12.0	32	13.0	1	3.3
Lofemenal	48	17.4	48	19.5	0	0.0
Ovrette	35	12.7	34	13.8	1	3.3
Injectable	129	46.7	129	52.4	0	0.0
Condom	30	10.9	2	0.8	28	93.3
Spermicide	1	0.4	1	0.4	0	0.0
Reason for Visit						
Non-FP visit	379	52.0	358	52.6	21	42.9
FP info only	25	3.4	20	2.9	5	10.2
To obtain FP method	318	43.6	295	43.4	23	46.9
Follow-up visit	7	1.0	7	1.0	0	0.0
Type of Information Desired*						
IUD	12	50.0	11	57.9	1	20.0
Lofemenal	1	4.2	1	5.3	0	0.0
Ovrette	1	4.2	1	5.3	0	0.0
Injectable	6	25.0	6	31.6	0	0.0
Condom	4	16.7	0	0.0	4	80.0
Type of Family Planning Method Received						
IUD	152	49.0	152	53.0	0	0.0
Lofemenal	21	6.8	21	7.3	0	0.0
Ovrette	10	3.2	10	3.5	0	0.0
Injectable	98	31.6	98	34.1	0	0.0
Condom	28	9.0	5	1.7	23	100.0
Spermicide	1	0.3	1	0.3	0	0.0

continued…

	Total		Female		Male	
	N	%	N	%	N	%
Total	**731**	**100**	**682**	**100**	**49**	**100**
Source of Information about the Clinic						
Poster	41	5.6	32	4.7	9	18.4
Provider	0	0.0	0	0.0	0	0.0
Friend from *séré*	139	19.0	139	20.4	0	0.0
Brochure	67	9.2	59	8.7	8	16.3
Animator	11	1.5	9	1.3	2	4.1
Family member	32	4.4	30	4.4	2	4.1
Rural radio	592	81.0	554	81.2	38	77.6
Other source	80	10.9	73	10.7	7	14.3
Heard of the IUD						
No	135	18.5	110	16.2	25	51.0
Yes	593	81.5	569	83.8	24	49.0
Source of Information about the IUD†						
Poster	39	6.5	31	5.4	8	33.3
Friend from *séré*	130	21.8	130	22.7	0	0.0
Community motivator	13	2.2	11	1.9	2	8.3
Provider	188	31.5	182	31.8	6	25.0
Family member	29	4.9	28	4.9	1	4.2
Rural radio	553	92.8	531	92.8	22	91.7
Imam	16	2.7	15	2.6	1	4.2
Brochure	58	9.7	49	8.6	9	37.5
Heard Imam Roundtable on Radio						
No	294	50.1	285	50.6	9	37.5
Yes	293	49.9	278	49.4	15	62.5
Campaign Messages Recalled†						
IUD is discreet	150	25.2	146	25.5	4	16.7
IUD is long acting	247	41.4	241	42.1	6	25.0
IUD is effective	165	27.7	157	27.4	8	33.3
IUD is affordable	58	9.7	51	8.9	7	29.2
IUD is reversible	149	25.0	140	24.5	9	37.5
IUD is easy to use	29	4.9	27	4.7	2	8.3
IUD causes no problems	4	0.7	4	0.7	0	0.0
IUD has few side effects	106	17.8	101	17.7	5	20.8
Other message	82	13.8	80	14.0	2	8.3
Accurately Recalled at Least One Message†						
No	76	12.8	74	12.9	2	8.3
Yes	520	87.2	498	87.1	22	91.7

* Among information-seekers only.
† Among those having heard of the IUD.

Appendix 11: Client Intake Data: Women Seeking Family Planning Services (by type of service)

	Total		Other FP services		IUD services	
	N	%	N	%	N	%
Total	**322**	**100**	**149**	**100**	**166**	**100****
Age	28.0	5.6	27.9	5.5	27.9	5.6
Has Children						
No	26	8.1	12	8.1	13	7.8
Yes	296	91.9	137	91.9	153	92.2
Mean No. of Children	4.1	2.1	3.9	2.0	4.2	2.1
Wants Children						
No	49	15.2	22	14.8	24	14.5
Yes	273	84.8	127	85.2	142	85.5
Desired Spacing of Children						
This year	43	16.0	39	31.0	4	2.9**
1-2 years	107	39.8	47	37.3	59	42.4
After 3 years	119	44.2	40	31.7	76	54.7
Family Planning User						
No	112	34.8	63	42.3	49	29.5
Yes	210	65.2	86	57.7	117	70.5**
Current Method of Family Planning						
IUD	30	14.3	2	2.3	24‡	20.5**
Lofemenal	38	18.1	14	16.3	23	19.7
Ovrette	27	12.9	8	9.3	19	16.2
Injectable	113	53.8	62	72.1	49	41.9
Condom	1	0.5	0	0.0	1	0.9
Spermicide	1	0.5	0	0.0	1	0.9
Reason for Visit						
Non-FP visit	0	0.0	0	0.0	0	0.0
FP info only	20	6.2	9	6.0	11	6.6
Receive FP method	295	91.6	140	94.0	155	93.4
Follow-up visit	7	2.2	0	0.0	0	0.0
Source of Information about the Clinic						
Poster	18	5.6	2	1.3	14	8.4
Provider	0	0.0	0	0.0	0	0.0
Friend from *séré*	87	27.0	27	18.1	58	34.9**
Brochure	46	14.3	11	7.4	34	20.5**
Animator	7	2.2	0	0.0	7	4.2**
Family member	22	6.8	6	4.0	15	9.0*
Rural radio	292	90.7	143	96.0	144	86.7**
Other source	3	0.9	1	0.7	1	1.2
Heard of the IUD						
No	18	5.6	11	7.4	7	4.2
Yes	303	94.4	138	92.6	158	95.8

continued…

	Total		Other FP services		IUD services	
	N	%	N	%	N	%
Total	**322**	**100**	**149**	**100**	**166**	**100****
Source of Information about the IUD†						
Poster	18	5.9	4	2.9	12	7.5*
Friend from *séré*	80	26.3	20	14.5	58	36.5**
Community motivator	9	3.0	0	0.0	9	5.7**
Provider	112	36.8	47	34.1	61	38.4
Family member	20	6.6	8	5.8	11	6.9
Rural radio	282	92.8	134	97.1	143	89.9**
Imam	12	3.9	3	2.2	9	5.7*
Brochure	36	11.8	7	5.1	28	17.6**
Heard Imam Roundtable on Radio						
No	131	43.7	71	52.6	57	36.1
Yes	169	56.3	64	47.4	101	63.9**
Campaign Messages Recalled†						
IUD is discrete	93	30.6	36	26.1	55	34.6*
IUD is longacting	146	48.0	66	47.8	77	48.4
IUD is effective	80	26.3	21	15.2	56	35.2**
IUD is affordable	10	3.3	4	2.9	5	3.1
IUD is reversible	41	13.5	18	13.0	21	13.2
IUD has few side effects	67	22.0	26	18.8	40	25.2
IUD is easy to use	16	5.3	5	3.6	11	6.9
IUD causes no problems	2	0.7	0	0.0	2	1.3
Other message	39	12.8	22	15.9	16	10.1*
Accurately Recalled at Least One Message†						
No	34	11.2	20	14.5	13	8.2
Yes	270	88.8	118	85.5	146	91.8*

* $p<.20$.
** $p<.05$.
† Among those having heard of the IUD.
‡ Of these 24 women, three were seeking information about the IUD and the remainder reported coming to the facility to obtain an IUD.