

Guidance for Monitoring and Evaluation of Community-Based Access to Injectable Contraception



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PROJECT DESCRIPTION

In response to global efforts to increase task shifting, whereby tasks traditionally performed by higher-level cadres of health care workers are shifted to lower-level cadres through training and mentoring, the World Health Organization (WHO) has issued guidance^{1,2} addressing which cadres of health care workers may provide particular services. Regarding family planning, the WHO guidance recommends lay health worker provision of injectable contraception with “targeted monitoring and evaluation.” While WHO did not define “targeted monitoring and evaluation” or expand upon specific circumstances under which lay health workers could provide injectable contraception, general consensus in the global family planning community is that the concerns are related to the safety of such a program. Can lay health workers provide injectables in a community setting with proper screening and aseptic techniques?

To assist countries in following the WHO recommendation, FHI 360 initiated a project to develop written guidance on monitoring and evaluation (M&E) of community-based access to injectable contraception (CBA2I), including recommended M&E indicators. This guidance and these indicators can be adapted for clients who self-inject and receive commodities through community distribution.

GOAL AND INTENDED USERS

The goal of this guidance is to strengthen CBA2I programs through improved M&E, resulting in increased access to and quality of family planning services. This guidance is intended for use by governments and programs or projects wanting to implement or improve their CBA2I programs, and specifically, the monitoring and evaluation of those programs.

METHODOLOGY FOR DEVELOPING GUIDANCE

This guidance was developed based on a literature review, a technical consultation with experts in the field, and case studies performed in three countries already implementing CBA2I programs. The document begins by describing the methods used and resulting findings, and goes on to recommend M&E indicators as well as processes and tools.

¹ World Health Organization (WHO). Health worker roles in providing safe abortion care and post-abortion contraception. Geneva: WHO; 2015. Available from: http://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion-task-shifting/en/.

² World Health Organization (WHO). WHO recommendations: Optimizing health worker roles for maternal and newborn health through task shifting. Geneva: WHO; 2012. Available from: <http://optimizemnh.org/>.

Literature review

We reviewed published literature, gray papers, and unpublished program and project summaries and program documents to better understand the status of M&E in countries implementing CBA2I programs, and to identify M&E indicators being used. This literature review also helped us to select countries for our case studies.

Technical consultation

In June 2016, we convened a group of international technical experts in the fields of M&E and family planning to gain input and buy-in for a set of standardized CBA2I indicators. The group met for two days and used a consensus-building facilitated process to develop a list of essential and expanded indicators. Participants were selected to represent various countries, levels of program implementation, and expertise in both family planning (with particular emphasis on injectable contraception) and M&E.

Case studies

To further examine the status of CBA2I M&E in several countries, we conducted case studies in three countries in sub-Saharan Africa. The countries were selected to represent various regions (including anglophone and francophone), a range of programs (national versus international nongovernmental organization (INGO), specific to certain geographical areas), longstanding programs, and newer ones.

We conducted interviews in each of the three case study countries ([Malawi](#), [Senegal](#), [Uganda](#)) with those involved with community-based provision of injectable contraception. Interview subjects included CBA2I program managers and administrators, such as higher-level government officials in the family planning division, district staff, facility-based staff, and community health workers (CHWs) who provide CBA2I. In addition, we spoke with personnel at INGOs who played a role in establishing CBA2I projects, specifically the M&E. Where possible, we collected relevant tools and job aids.

TECHNICAL CONSULTATION FINDINGS AND RECOMMENDED INDICATORS

Based on the expert technical consultation held in 2016, we recommend the following indicators (see next page) for use in programs implementing CBA2I to assist meeting WHO standards for M&E. Essential indicators are listed in bold; these are the bare minimum needed to ensure the safety and effectiveness of a CBA2I program.

Recommended Indicators for Targeted Monitoring and Evaluation of Community-Based Access to Injectable Contraception (CBA2I) *(indicator numbers in parentheses)*

Training

In most cases training data would be collected by training program managers at a facility level or higher.

- # of CHWs trained in providing injectable contraception (1.1)
- # of CHWs who passed a post-training test on injectable contraception (1.2)
- **#/% of CHWs certified to inject contraception (1.3/1.4)**
- #/% of CHWs certified to provide injectable contraception who express confidence in their skills and abilities (1.5/1.6)
- # of training courses held on community-based provision of injectable contraception (1.7)

Supervision

Those responsible for supervision should most commonly track and report data on the number of individuals and dates of supervision sessions they conduct. These individuals will most commonly be facility-based staff.

- **#/% of CHWs certified during the *previous* reporting period who received at least one in-person supportive supervision visit for providing injectable contraception within [x] months after successful completion of practicum (2.1/2.2)**
- #/% of CHWs supervised in-person at least once within [x] months after successful completion of practicum *who demonstrated adequate skills at the time of first supervision* (2.3/2.4)

Readiness

The first three of these four readiness indicators would most commonly be collected by CHW supervisors or program managers at a facility level or higher. CHWs would report data on stock-outs they experienced.

- #/% of CHWs certified in providing injectable contraception who have given an injection in the last quarter (3.1/3.2)
- #/% of villages/catchment areas with a CHW certified to provide injectable contraception (3.3/3.4)
- # of households served per CHW (3.5)
- **#/% of CHWs reporting a stock-out of injectables (3.6/3.7)**

Service Delivery

These indicators would be collected by CHWs.

- # of CHW-led mobilization events (4.1)
- # of one-on-one family planning (FP) counseling sessions held by CHWs (4.2)
- **# of injections provided (4.3)**
- # of reportable incidents including accidental needle sticks, or infections or abscesses at the site of the injection (4.4)

Data Quality

Individuals receiving the data from the CHWs should collect and compile data for these indicators; they will most commonly be CHW supervisors.

- #/% of CHWs submitting client data reports on time (5.1/5.2)
- #/% of CHWs submitting complete client data reports (5.3/5.4)
- #/% of CHWs submitting reports with reasonable accurateness (5.5/5.6)

*** Essential indicators in bold**

ESSENTIAL INDICATORS

This section further explains the rationale behind the four essential indicators.

- **#/% of CHWs certified to inject contraception**—Program managers should use this indicator to know that the number of CHWs certified to inject contraception is adequate to meet project goals. If programs increase demand for a service they are unable to meet, this will ultimately decrease demand again and may jeopardize the program altogether. By considering the percent of those trained who are certified, program managers have one way to check the quality of their training. Most of those trained should be able to be certified within the program’s regular certification time frame and process.
- **#/% of CHWs certified during the *previous* reporting period who received at least one in-person supportive supervision visit for providing injectable contraception within [x] months after successful completion of practicum**—As we learned through our case studies, supervisory visits play an extremely important role in monitoring the safety of CBA2I programs. While programs may vary in the intervals of supervisions, we recommend at least one visit per month in the first few months immediately following certification. After a CHW is known to provide high quality injectable services, the supervisions may be reduced to quarterly. If CHWs are not being supervised on time, according to program goals, program managers should consider what needs to be done to ensure that supervision can be more timely.
- **#/% of CHWs reporting a stock-out of injectables**—Just as programs need to ensure that enough CHWs are available, they must also have sufficient stocks of injectables to meet demand. Creating a service that women rely upon in their community that has interrupted availability is not only frustrating for clients but potentially harmful if they cannot receive reinjections on time, resulting in increased side effects or an unwanted pregnancy. Stock-outs should be extremely limited or nonexistent, and any reports of regular stock-outs should be investigated immediately.
- **# of injections provided**—At a bare minimum, the number of injections provided can help program managers understand whether they have created enough demand for CBA2I services or are falling short. Among the reasons for limited demand are mistrust of the service due to rumors or known problems or problems with reliability of services or commodities. Tracking the number of injections provided compared with program targets and past trends will help program managers identify concerns early.

The full list of indicators including definitions and additional information can be found at the end of this document.

CASE STUDY FINDINGS

The following section summarizes responses given in interviews conducted in our three case study countries (Malawi, Senegal, and Uganda).

CBA2I policy and practice

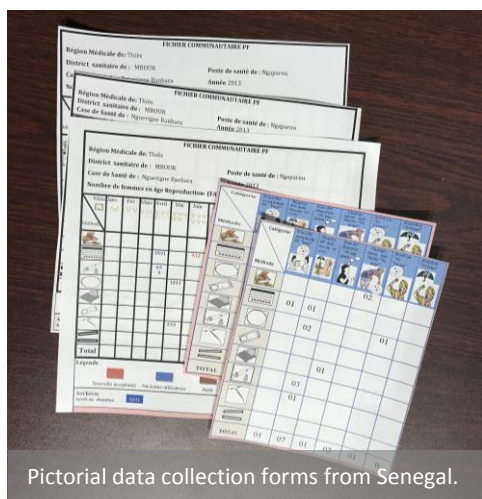
In our three case study countries, we found many similarities in how CHWs were organized and supervised. In all three, CHWs reported to a facility-based supervisor. They checked in with their supervisors approximately monthly to provide data from the previous month and pick up commodities for the following month.

Of the three countries, Malawi is the only one with a truly nationalized program. Its workers and the program are paid for and supported at the centralized government level. While Senegal has a national policy of providing CBA2I, it is implemented through various INGO partners and is active in approximately 90 percent of health huts. Uganda's public-sector CHWs are supported by specific INGO projects and its CBA2I program is implemented in approximately one-third of districts.

Minimum educational requirements for CHWs varied from a primary education in Senegal and Uganda to secondary school completion in Malawi. In Uganda and Malawi, the CHWs are expected to be literate, whereas in

Senegal, CHWs with limited literacy can implement the CBA2I service. In fact, the data collection forms in Senegal are designed pictorially to accommodate those with limited literacy. Basic CHW training varied depending on the expected tasks of CHWs in the three countries, but additional training on

injectables was between one and two weeks with the time divided to include both classroom theory and hands-on practicums (Table 1). Malawi was the only one of our three case study countries where CHWs were paid a regular salary. In Senegal, payment was at the discretion of the local health sector management and, in Uganda, they were volunteers.



Pictorial data collection forms from Senegal.

Table 1. CHW training requirements

Country	Basic CHW Training	Injectables Training
Senegal	1-2 weeks	3 days theory 5 days practicum
Malawi	10 weeks	2 days theory 3 days practicum
Uganda	1 week	7-10 days (first week theory, second week practicum)

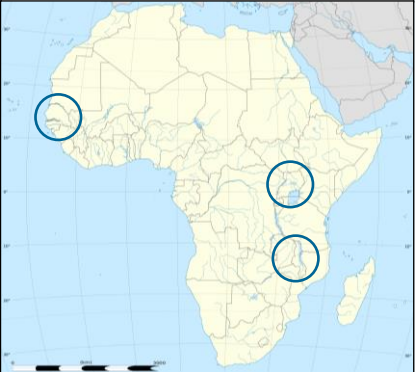
Recognition of WHO guidance

Most of the subjects we interviewed had not heard of the WHO recommendations regarding “targeted M&E” for lay health worker provision of injectable contraception, and none reported that their countries’ indicators had been developed or revised in light of the recommendation.

Data collection, use, and reporting

Uganda and Senegal are able to track CHW activities separately from facility-based activities; in Malawi, however, the data are consolidated at the facility level. The number of clients served, including new users, and information on commodities were the most commonly collected indicators. None of the three countries, however, regularly tracked stock-outs as a specific community-based activity indicator.

While supervisions took place, neither frequency nor results were part of the M&E system in any of the three countries. Similarly, none of the countries tracked training for CHWs on injectables as a part of their regular M&E, and only Uganda tracked referrals to other providers or clinics. None of the countries reported tracking adverse events such as infections at the site of the injection, because, according to those we interviewed, they do not happen often enough to be a concern. Rather, the countries reported that adverse events would be raised through their regular supervision process. In Malawi, anything unusual would be reported through monthly meetings of family planning coordinators, but the family planning coordinators we spoke with could not recall any adverse event incidents.

Current indicators		
<p>Senegal</p> <ul style="list-style-type: none"> # of clients counseled <ul style="list-style-type: none"> • initial counseling • method specific counseling # who adopted a method, by method Quantity of supply given Recruitment rate Contraceptive prevalence rate Discontinuation rate Couple years of protection 	<p>Uganda</p> <ul style="list-style-type: none"> # of clients counseled # of new FP acceptors (disaggregated by age) # of returning FP clients (disaggregated by age) Type of FP methods dispensed (disaggregated by age) # of clients referred for side effect management and long-term methods Couple years of protection Current or past clients switching from different methods 	<p>Malawi</p> <ul style="list-style-type: none"> # of women receiving a method <ul style="list-style-type: none"> • # per method • # of new users • # of continuing users • Age (disaggregated by under 20 and over 20)
		

RECOMMENDATIONS

We recommend that countries or programs implementing CBA2I consider the following practices as a part of their CBA2I programs. These recommendations aim to ensure high-quality M&E systems are in place as well as the safety of CBA2I programs.

Conduct regular supervision—Supervision plays a key role in ensuring program quality. When conducted immediately after training or certification, this can help CHWs feel supported by their supervisors and build the trust needed to bring up implementation problems or remaining knowledge/skill gaps. Supervisory sessions are also the most appropriate place to identify problems that may impact the safety of patients and CHWs. A clinical supervisor can immediately correct for poor practices that may lead to problems such as infections. We discussed with both our group of technical consultants and our case study interview subjects how to track these adverse reactions or, what we refer to as “reportable incidents,” in our indicators list. The experts and interview subjects agreed that adverse events happened rarely, if ever, and are best handled through supervisions. As a result, we did not include reportable incidents as an essential indicator for three reasons. First, as stated, clinically trained supervisors will best be able to intervene and understand why the problem occurred and how to handle it. Second, M&E data is aggregate data and not client specific, making it difficult to know the circumstances and context of the incident. Third, by the time M&E data are compiled and analyzed, several months may have passed, making it too late for any

necessary immediate intervention. While a reporting mechanism for safety-related incidents should be in place to know exactly how rare they are, they should first be dealt with as efficiently and effectively as possible through clinically trained supervisors. The frequency of ongoing supervisions can be determined locally, but a regular schedule should be adhered to.

Key elements to be included in a CBA2I supportive supervision are:

- A review of proper counseling and screening
- A review of proper injection techniques
- A review of how records are kept, forms completed, and M&E data compiled
- A review of how and when referrals to a facility are made
- A review of which commodities are available, how they are stored, and how waste is handled

Deliver quality training on data collection and use—Data collection should be made as easy as possible for CHWs, while at the same time representing a comprehensive set of indicators. CHWs should receive quality training on how to collect data, as well as on how data are used so they fully understand the importance of the data they collect. In addition, programmatic results should be communicated back to CHWs so they not only understand how the data they collect are used but also have feedback on their own group performance. A full understanding of the process from collection to use will improve the quality of data collected.

Ensure timely submission of accurate data reports

—CHWs should report their collected data on a regular basis (in most cases monthly). Those responsible for compiling the data should have error checks in place (for example, the number of new users cannot exceed number counseled) and should work with CHWs to correct any data deficiencies or errors as quickly as possible.

Analyze and use data at multiple levels—Data should be analyzed and used by relevant staff at all programmatic levels. While there is shared responsibility for using the data for program improvement, each level may also focus on different elements of the data. For example, whereas first-line supervisors might check that M&E data are reasonable for the catchment area and ensure that CHWs are performing in accordance with expectations, facility-level managers might work to ensure that they have adequate supplies of commodities to meet client needs. District-level managers can ensure that all facilities within the district perform in accordance with programmatic goals, and at the national level, analysis will demonstrate whether the program helps to improve or sustain goals such as contraceptive prevalence rates and reduced unmet need for family planning. These and other performance elements should be discussed at regular data review meetings, which we suggested holding at least semi-annually, if not quarterly.

Conduct data quality assessments (DQAs)—DQAs are an essential M&E practice. FHI 360 recommends that DQAs be implemented during the first year of project start-up, within six – 12 weeks after beginning data collection. Repeated implementation would ideally occur once each quarter per site throughout the life of the project. The frequency of implementation can be reduced once pre-set criteria are met.

For more information on conducting a DQA, see FHI 360 and USAID’s DQA guidance:

- <https://www.fhi360.org/sites/default/files/media/documents/fhi360-dvt-oct2013.pdf>
- <https://usaidlearninglab.org/sites/default/files/resource/files/cleared - how-to note - conduct a dqa.pdf>
- <https://usaidlearninglab.org/sites/default/files/resource/files/cleared - ah - dqa checklist.pdf>

Specific to sampling for CHWs for DQAs, we recommend lot quality assurance sampling (LQAS), which requires smaller sample sizes than stratified sampling.

Offer regular refresher training—Refresher training on injectable provision by CHWs should be offered at least

annually. This is an important time for CHWs to come together to see if recommended practices have changed and to ensure they are correctly performing their duties. This training should also include a strong M&E component, including how data are correctly collected, compiled, and reported.

Recognize and support CHWs—Supporting and recognizing the importance of the work of CHWs is key to implementing a successful program. As is true for most employees, when CHWs can take pride in their work, they are more likely to be successful. This can be accomplished in a variety of ways. In Uganda, for example, CHWs and the importance of their work are regularly recognized when they come in to the health facility to pick up resupply of commodities or report data. According to interview subjects in Uganda, this helps keep the CHWs motivated and reinforces the important role they play to other members of the health care system.

WHO noted that “existing CHW programs vary greatly in their level of impact—with some of the highest performing CHW systems being ones in which CHWs are formalized, paid, and given other appropriate incentives.”³ In addition, research has found that performance-based financial incentives can improve performance but sometimes results in neglect of unpaid tasks.⁴ As M&E is not normally a performance based task, without regularly paid CHWs, programs run the risk of collecting sub-par data.

RECOMMENDED TOOLS/JOB AIDS

The following tools can greatly assist CHWs in performing their M&E role in CBA2I. (See sample forms pages 8-9.)

- Data collection tool
- Data compilation form/tally sheet
- Pictorial data collection forms (as necessary for CHWs with limited literacy)

In addition, FHI 360 has developed service delivery tools and job aids for providers—practical materials to use when serving clients in clinical or community-based settings. The tools/job aids reflect the latest WHO recommendations and are available at: <https://www.fhi360.org/resource/service-delivery-tools-and-job-aids-family-planning-providers>.

³ World Health Organization (WHO). Strengthening primary health care through community health workers: investment case and financing recommendations. Geneva: WHO; 2015. Available from: <http://www.who.int/hrh/news/2015/CHW-Financing-FINAL-July-15-2015.pdf>

⁴ Kok MC, Dieleman M, Taegtmeier M, Broerse JE, Kane SS, Ormel H, Tijm MM, de Koning KA. Which intervention design factors influence performance of community health workers in low- and middle-income countries? a systematic review. Health Policy Plan. 2015;30(9):1207-27.

HOW TO UPDATE A CBA2I M&E SYSTEM

Efforts to update M&E systems need to be tailored to the relevant programmatic levels—catchment area, facility, district, region, national—and may require a coordinated multilevel strategy.

National

- Engage key stakeholders responsible for the M&E system at all levels, especially those who coordinate implementation: influential officials are critical.
- Remind decision makers of the benefits of updating the M&E system/data collection.
- Encourage national programs to invest in building the M&E capacity of front-line health staff and district-level data managers. Strengthening overall performance of lower-levels will contribute to national capacity and vice versa.
- Plan for a participatory process to determine what actions to take. Teams can be essential for keeping the issue visible, solving problems, and tracking and informing each step.
- Capitalize on opportunities for making M&E changes in existing cycles of strategic program reviews, planning, or implementation which should include assessment of M&E performance and systems. In some cases, it is both desirable and feasible to integrate data collection forms and data management systems.

District/Regional

- Participate in, support, or organize a hands-on exchange with a CBA2I program where M&E data forms and protocols have already been updated.
- Determine if a specific component of the system can be changed as needed. To create momentum, you may need to flag a problem with the current system, such as not collecting data that tracks CHW activities separately from facility-based activities.

Local/Facility

- Staff should identify where new indicators can be added to current forms or whether new forms need to be developed. Sample services and commodity tracking forms, included on pages 8-9, can be modified to meet local needs.
- Conduct field tests on the usability of revised indicators and forms.
- Train CHWs, supervisors, and M&E officers as part of the rollout.

Services Tracking Form for CHW Program

FP/RH Services Provided by CHWs

This form is used by a CHW supervisor to summarize monthly data about new and continuing users submitted by each CHW.

Month/year reported: Jan / 2018

CHW Name	Date	DMPA			DMPA-SC			Pills		ECPs	CycleBeads		LAM		Male Condom		Female Condom		Total Users		
		DDMMYY	New	Cont	On time	New	Cont	On Time	New	Cont	-NA-	New	Cont	New	Cont	New	Cont	New	Cont	New	Cont
1. A. Banda	1/1/18	3	6	6	1	3	2	4	8	2	0	2	4	2	6	2	1	0	19	23	
2. J. Mwangi	3/1/18	4	5	5	2	3	3	4	6	2	2	1	6	3	6	4	0	0	24	22	
3.																					
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7.																					
8.																					
9.																					
10.																					
11.																					
12.																					
13.																					
14.																					
15.																					
Totals:																					
Referrals	1. 2	2. 1	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	Total					
FP counsel	1. 22	2. 27	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	Total					
New FP users	1. 6	2. 8	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	Total					
Reportable Incident	1. 0	2. 0	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	Total					

Each CHW's monthly data is entered on a separate line.

For DMPA-IM and DMPA-SC, in addition to tracking the number of new and continuing users, for continuing users the CHW also tracks whether the subsequent injection was given on time (within the grace period).

A total of all new and continuing users for the month for each health worker is calculated.

Other indicators, such as those listed here, can be tracked at the bottom of the sheet, corresponding to each CHW listed above.

An editable version of these sample forms, adaptable to specific countries, can be requested from cba2i@fhi360.org or are available in the [CBA2I Toolkit](#) on the K4Health site.

Remarks: _____

Name of health facility: _____ Name of CHW supervisor: _____

Signature of CHW supervisor: _____ Date form submitted: _____

Recommended Community-Based Access to Injectable Contraception (CBA2I) Indicators and Definitions

Community-based access to injectable contraception (CBA2I) refers to community health workers (CHWs) providing injectable contraception at the community level. While this practice sometimes takes place at community-level structures, such as health huts, it can also occur in providers' or clients' homes, or in open settings in the community.

In the World Health Organization (WHO) 2011 [Optimizing Health Worker Roles for Maternal and Newborn Health through Task Shifting](#), lay health worker provision of injectable contraception is recommended along with

“targeted monitoring and evaluation,” but the concept is not further defined. The following indicators were developed by FHI 360 in collaboration with a group of technical experts in the field in response to the recommendation for targeted monitoring and evaluation. Essential CBA2I indicators are presented first and are considered the bare minimum for programs to use to monitor a CBA2I program. They are followed by the full, expanded list, which program managers may consider and adapt as resources allow.

Essential CBA2I Indicators			
Number	Indicator	Definition	Additional information
1.3/1.4 (Training)	#/% of CHWs certified to inject contraception	Of those CHWs trained and reported in indicator 1.1, the number who passed a post-training practicum and became certified to offer injectable contraception	Criteria for passing a post-test will vary by program/country, but should include questions to ensure CHWs can properly screen for initiation of injectable contraception and can identify conditions that would require discontinuation. In most cases, only those who pass the written test should be eligible to take the practicum. The numerator can then be the number passing the practicum and the denominator the total number trained. Numerator: 1.3 Denominator: 1.1
2.1/2.2 (Supervision)	#/% of CHWs certified during the <i>previous</i> reporting period who received at least one in-person supportive supervision visit for providing injectable contraception within [x] months after successful completion of practicum	Appropriate length of time after training to be defined by in-country standards Supervision should include both counseling and injection skills, cover reiterative skills, and address gaps	The technical experts recommend that CHWs receive at least one supportive supervision in the first month after successful completion of the practicum. Looking at those certified during the previous reporting period allows enough time to have passed for the opportunity of supervision to have occurred. Supervision should include both counseling and injection skills, cover reiterative skills, and address gaps. Numerator: 2.1 Denominator: 1.5
3.6/3.7 (Readiness)	#/% of CHWs reporting a stock-out of injectables	# of CHWs within the authorized cadre who reported having an inadequate supply of injectable contraception	Programs may also wish to further disaggregate by other needed materials such as alcohol swabs or bandages. Numerator: 3.6 Denominator: 3.1
4.3 (Service provision)	# of injections provided	# of injections provided to any type of client (new users or those receiving a resupply) during the reporting period	Disaggregation by: # of clients new to family planning (FP) (first FP use ever) # of clients new to the method, but had previously used FP # of resupply injections # of on-time injections (within grace period)

Expanded Indicator List			
Number	Indicator	Definition	Additional information
Training			
1.1	# of CHWs trained in providing injectable contraception	# of CHWs completing a full training course in provision of injectable contraception during the reporting period, regardless of the outcome of any post-test and/or practicum	None
1.2	# of CHWs who passed a post-training test on injectable contraception	Of those CHWs trained and reported in 1.1, the number who passed a post-training test	Criteria for passing the post-test will vary by program/country
1.3 (#) 1.4 (%)	#/% of CHWs certified to inject contraception	Of those CHWs trained and reported in 1.1, the #/% who passed a post-training practicum and became certified to offer injectable contraception	<p>Criteria for passing the post-test will vary by program/country, but should include questions to ensure CHWs can properly screen for initiation of injectable contraception and identify conditions that would require discontinuation.</p> <p>In most cases, only those who pass the written test should be eligible to take the practicum. The numerator can then be the number passing the practicum and the denominator the total number trained.</p> <p>Numerator: 1.3 Denominator: 1.1</p>
1.5 (#) 1.6 (%)	#/% of CHWs certified to provide injectable contraception who express confidence in their skills and abilities	#/% of CHWs who respond positively to a written or oral question at the end of their training, such as in a post-training test or survey, expressing confidence in their skills and abilities to provide injectable contraception. This is intended to avoid situations where CHWs are certified, but not offering injectables as a contraceptive option. For example, "Having completed this training, I feel confident in my skills to provide injectable contraception. Circle one: Agree/Disagree"	Numerator: 1.5 Denominator: 1.3
1.7	# of training courses held on community-based provision of injectable contraception	# of training courses held on community-based provision of injectable contraception during the reporting period	<p>Disaggregation: # of initial training courses for providers held # of train-the-trainers courses held # of refresher courses held # of participants</p> <p>This indicator helps monitor whether training happens, how often, and the number of attendees.</p>

Supervision			
2.1 (#) 2.2 (%)	#/% of CHWs certified during the <i>previous</i> reporting period who received at least one in-person supportive supervision visit for providing injectable contraception within [x] months after successful completion of practicum	#/% of CHWs certified during the previous reporting period who have received at least one in-person supportive supervision visit for providing injectable contraception within [x] months after successful completion of practicum	<p>The appropriate length of time after training is defined by in-country standards, but the technical experts recommend that CHWS receive at least one supportive supervision in the first month after successful completion of the practicum.</p> <p>Looking at those certified during the previous reporting period allows enough time to have passed for the opportunity of supervision to have occurred.</p> <p>Supervision should include both counseling and injection skills, cover reiterative skills, and address gaps.</p> <p>Numerator: 2.1 Denominator: 1.5</p>
2.3 (#) 2.4 (%)	#/% of CHWs supervised in-person at least once within [x] months after successful completion of practicum <i>who demonstrated adequate skills at the time of first supervision</i>	<p>Adequate skills determined by each country/program</p> <p>#/% of those supervised who demonstrated adequate skills; adequate skills determined by each country/program</p>	<p>Numerator: 2.3 Denominator: 2.1</p>
Readiness			
3.1 (#) 3.2 (%)	#/% of CHWs certified in providing injectable contraception who have given an injection in the last quarter	<p>#/% of CHWs certified in providing injectable contraception who have given a client an injection in the last quarter</p> <p>To avoid double counting CHWs, this indicator should not be added to previous quarters, but rather compared with them.</p>	<p>Include not only those trained and certified in the reporting period but also all certified and active CHWs.</p> <p>The denominator would include all active, certified CHWs, not only those who were certified in the reporting period.</p> <p>Numerator: 3.1 Denominator: Total # of certified CHWs</p>
3.3 (#) 3.4 (%)	#/% of villages/catchment areas with a CHW certified to provide injectable contraception	<p>#/% of villages/catchment areas with a CHW certified to provide injectable contraception</p> <p>Catchment area defined by each program/country</p>	<p>Numerator: 3.1 Denominator: Total # of villages/catchment areas</p>
3.5	# of households served per CHW	The average number of households served by each CHW.	<p>Numerator: Number households in a catchment area in the reporting period. Denominator: Total number of active CHWs in the catchment area in the reporting period.</p>

3.6 (#) 3.7 (%)	#/% of CHWs reporting a stock-out of injectables	#/% of CHWs within the cadre who reported having an inadequate supply of injectable contraception on any day during the reporting period	Programs may also wish to further disaggregate by other needed materials such as alcohol swabs or bandages. Numerator: 3.6 Denominator: 3.1
Service Delivery			
4.1	# of CHW-led mobilization events	# of family planning mobilization/ demand creation events led by CHWs during the reporting period	None
4.2	# of one-on-one FP counseling sessions held by CHWs	# of one-on-one FP counseling sessions held by a CHW about FP options during the reporting period.	None
4.3	# of injections provided	# of injections provided to any type of client (new users or those receiving a resupply) during the reporting period.	Disaggregation by: # of clients new to FP (first FP use ever) # of clients new to the method, but had previously used FP # of resupply injections # of on time injections (within grace period)
4.4	# of reportable incidents including accidental needle sticks, or infections or abscesses at the site of the injection	# of incidents needing to be referred for further follow-up. Reportable incidents do not include expected side effects of the method, but may include, accidental needle sticks, or infections or abscesses at the site of the injection, for example.	None
Data Quality			
5.1 (#) 5.2 (%)	#/% of CHWs submitting data reports on time	#/% of CHWs submitting data reports on time "On time" to be defined by each country/program, but is often the fifth of the month for the previous month.	Data reports include whatever information is expected to be reported from CHWs on a regular (usually monthly) basis. It will likely include the number of clients counseled, the number of methods provided, etc. Numerator: 5.1 Denominator: 3.1
5.3 (#) 5.4 (%)	#/% of CHWs submitting complete client data reports	#/% of CHWs submitting reports with at least 80% of data points complete	Numerator: 5.3 Denominator: 3.1
5.5 (#) 5.6 (%)	#/% of CHWs submitting reports with reasonable accurateness	#/% of active CHWs submitting reports with 80% of data points less than or equal to 5% variation, as determined by soft data checks and regular data cleaning	Numerator: 5.5 Denominator: 3.1

