# Community Health Worker
## Provision of Injectable Contraception





**AN IMPLEMENTATION HANDBOOK**

fhi360
THE SCIENCE OF IMPROVING LIVES

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## Community Health Worker Provision of Injectable Contraception: An Implementation Handbook

This handbook is dedicated to the women, men, and stakeholders who contributed to advancing CBA2I from an emerging innovation to a widely implemented best practice.

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## About This Handbook

This handbook outlines the nine basic components of a community-based family planning program that includes injectables within the method mix provided by community health workers (CHWs). An earlier version of this handbook was published in 2008 based on the experiences of Uganda and Madagascar. The original handbook has been updated here to include more in-depth content based on 15 years of experience and a global body of research from ministries of health, community-based organizations, national and international nongovernmental organizations, and other institutions from more than a dozen countries.

This handbook provides program managers, policy makers, and those interested in expanding access to family planning with insight to prepare, initiate, and scale up the provision of injectable contraception by CHWs. The lessons presented in this handbook were gleaned from research studies, programmatic reports, international medical guidance, and subject matter experts. FHI 360's team of research and research utilization specialists have collected these lessons since the practice of CHW provision of injectable contraception was first introduced in sub-Saharan Africa in 2004.

The appendices contain a collection of checklists, training materials, sample forms, and other resources that can help you introduce and scale up CHW provision of injectable contraceptives. You are welcome to adapt and improve these tools to suit your circumstances.

We are eager to hear about your experiences using this handbook as well as your suggestions on ways to improve it. Please direct your comments to:

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## Acronyms

| | |
|---|---|
| **CBA2I** | Community-Based Access to Injectables |
| **CBFP** | Community-Based Family Planning |
| **CIP** | Costed Implementation Plan |
| **CHW** | Community Health Worker |
| **CRTU** | Contraceptive and Reproductive Health Technologies Research and Utilization |
| **CYP** | Couple-Years of Protection |
| **DMPA** | Depot-Medroxyprogesterone Acetate |
| **DMPA-IM** | Intramuscular Depot-Medroxyprogesterone Acetate |
| **DMPA-SC** | Subcutaneous Depot-Medroxyprogesterone Acetate |
| **HMIS** | Health Information Management System(s) |
| **M&E** | Monitoring and Evaluation |
| **MOH** | Ministry of Health |
| **NET-EN** | Norethisterone enanthate |
| **NGO** | Nongovernmental Organization |
| **PROGRESS** | Program Research for Strengthening Services |
| **VHT** | Village Health Team |
| **WHO** | World Health Organization |

## Table of Contents

## Introduction

The majority of developing countries face critical shortages of doctors, nurses, and midwives.[1] Moreover, health professionals are concentrated in urban areas, leaving rural health facilities severely understaffed and under-resourced. In both rural and urban underserved areas, the supply of modern contraceptive methods and health personnel to provide them are often limited, making access to family planning extremely difficult. Injectables are the most preferred family planning method in many parts of the world, yet accessing them remains a major challenge. At the same time, there is a growing demand for family planning services and a global resurgence in efforts to meet the family planning needs of women and girls. Despite the largest cohort of young people in history approaching reproductive age, many barriers remain for those who want to use contraception.

One way to meet the demand for injectables is through programs that expand community-CBA2I through community health workers (CHWs). CHW provision of injectable contraception has been used to expand the method mix at the community level since the 1970s. In Bangladesh, depot-medroxyprogesterone acetate (DMPA) was first offered in 1977 in the Matlab subdistrict. For nearly four decades, programs in Latin America, Asia, and Africa have consistently shown that provision of injectables

by CHWs can be an extremely safe and effective way to provide family planning services. Research findings and programmatic evidence repeatedly demonstrate that trained CHWs can:

- Provide injections safely, using proper techniques to prevent infection
- Refer clients to a clinic
- Maintain their supplies
- Safely dispose of needles and syringes
- Counsel their clients about side effects
- Administer injectables on a regular schedule

### A Note on Terminology

The term "community-based access to injectables" (CBA2I) describes multiple approaches to expanding the method mix at the community level in both rural and urban areas. CBA2I includes the sale or provision of injectables in drug shops or pharmacies, at health posts, through outreach services, or through CHWs who are part of a larger community-based family planning (CBFP) program. This handbook only addresses the provision of injectables by CHWs as part of a CBFP program.

Sub-Saharan Africa's first documented effort to expand CBA2I began in Uganda's Nakasongola district in 2004 and continues today. With policy change enacted and scale-up underway, Uganda, Madagascar, and Malawi were early adopters of the practice and pioneered the provision of injectables by CHWs throughout the continent. As of 2018, 12 countries in sub-Saharan Africa have adopted policies that support CBA2I, six countries have policy dialogue and scale-up underway, and two additional countries have completed pilots or have pilots underway.



At the time of this writing, in Pakistan, FHI 360 and the Aga Khan University (AKU) in collaboration with Jhpiego, USAID, and the Government of Sindh province conducted a randomized controlled trial (RCT) that compared screening and counseling for DMPA by the lay cadre, Lady Health Workers (LHWs) and their clinically-trained counterparts, Lady Health Visitors (LHVs). Preliminary results of the study revealed that rural providers performed better than their urban counterparts. In urban

## Who Are CHWs and Where Do They Work?

CHWs are trusted members of the community who are trained to provide family planning services and information about reproductive health in a private and confidential setting. CHWs are linked with community health facilities, district health offices, and in some countries national ministries of health (MOH) and nongovernmental organizations (NGOs).

The provision of CBFP services and methods may take the form of visits to a client's home or visits to a community health post, marketplace, or other meeting place.

Without these CHWs, women often travel long distances to reach the nearest clinic, or they may simply do without family planning services. Although CBFP programs are traditionally implemented in rural areas, this approach may also be used in urban areas where access is limited.

Terms for CHWs vary considerably by country. CHWs may be known as community health volunteers, community health officers, community-based distribution agents, village health workers, or other terms. For consistency, only "CHW" will be used in this handbook.[2]

areas, LHWs did not perform as well as the LHVs. In rural areas, performance of the two groups was similar, and the lay cadre appeared to out-perform the higher-level cadre in some respects.

Within the past 15 years, CHW provision of injectable contraception has become a global standard of practice with guidance from the World Health Organization (WHO) and other normative bodies, based on the best available evidence.

For example:

- A June 2009 technical consultation at WHO concluded that there is sufficient evidence to support expansion of CHWs providing injectable contraception.[3]
- In 2011 and 2015, USAID recognized that CHW provision of family planning can increase the use of contraception, particularly where unmet need is high, access is low, and geographic or social barriers to use of services exist. This includes CHW provision of injectables.[4]
- WHO's 2012 task-sharing recommendations contained in the OptimizeMNH guidance state that with targeted monitoring and evaluation (M&E), trained CHWs can both initiate and reinject injectable contraceptives using a standard syringe.[5]
- USAID's 2013 high impact practice brief details expanding family planning through drug shops and pharmacies.[6]
- WHO's 2015 and 2017 guidance documents include recommendations for task sharing the provision of family planning through CHWs.[7,8]

## What Are Injectable Contraceptives?

Injectable contraceptives are highly effective, reversible, easy to use, and private. Women who use them are less likely to have cancer of the lining of the uterus (i.e., endometrial cancer), uterine fibroids, anemia, or symptomatic pelvic inflammatory disease. Disadvantages include a possible delayed return to fertility—by an average of nine months after the last injection. Women may also experience prolonged, heavy, or irregular menstrual bleeding, especially during the first three to six months of use. After the first year, many women develop amenorrhea (i.e., the absence of menstrual bleeding). Other side effects may include weight gain, headaches, and nausea. DMPA, which is administered every three months, is the most common type of injectable contraceptive. In some countries, a two-month injectable called norethisterone enanthate (NET-EN) (also known as Noristerat) is used. In this handbook, intramuscular DMPA (DMPA-IM) will refer to both DMPA and NET-EN.

Emerging evidence shows that a new formulation of DMPA is a game changer in the field of CHW provision of injectable contraception. Subcutaneous DMPA (DMPA-SC) is a formulation that has been developed for injection into the tissue just under the skin. DMPA-SC is still a three-month, progestin-only injectable, but this formulation is packaged in the Uniject™ syringe system, which comes pre-filled with a single dose and cannot be reused. This design can help overcome logistic and safety challenges in delivering injectables since fewer commodities can simplify inventory management, decrease waste, and simplify the injection procedure for nonclinical health workers. The subcutaneous formulation offers the same efficacy and length of protection as the intramuscular formulation, but it contains a 30-percent lower dose. Administering DMPA-SC is also simpler because the needle is shorter and is injected just under the skin instead of deeper into the muscle. Sayana Press is the trade name for the currently available DMPA-SC product.

New research shows that self-injected contraceptives can increase the continued use of contraception among women in low-resource settings, where the availability of high-quality contraceptives—and health clinics where they can be administered—is limited.[9]

| Feature | DMPA-IM | DMPA-SC (Sayana Press) |
|---|---|---|
| Dose | 150 mg | 104 mg |
| Package | Vial and syringe | Prefilled Uniject injection system |
| Type of injection | Intramuscular (deep into the muscle); 3.8-cm needle | Subcutaneous (in the fatty tissue under the skin); 2.5-cm needle |
| Where to inject | • Arm (deltoid muscle)<br>• Hip<br>• Buttocks | • Anterior thigh (front of thigh)<br>• Abdomen<br>• Back of arm |
| Skin irritation | Skin irritation at injection site it not likely | Skin may be a little irritated at injection site |

# The 9 components

There are nine basic components needed to establish and manage a community-based program to distribute injectable contraceptives. These components will help policy-makers and program managers determine whether they can provide the service. It is important to recognize that many of the components must be considered together, even during the early stages of a pilot project. Each component is addressed in detail in the remaining sections of this handbook.

## Component 1

Determine the Feasibility of and Need for CHW Provision of Injectables

## Component 2

Evaluate the Potential Costs of Adding Injectable Contraceptives to a Community-Based Family Planning Program

## Component 3

Integrate CHW Provision of Injectables into National Policy and Service Guidelines

## Component 4

Mobilize the Community and Raise Awareness of the Service

## Component 5

Ensure a Logistical System that Supports Proper Waste Management and a Steady Provision of Supplies

## Component 6

Train Community Health Workers to Provide the Service

## Component 7

Establish Systems for Supportive Supervision

## Component 8

Document and Share Processes and Outcomes

## Component 9

Ensure Successful Scale-Up

# Component 1

## Determine the Feasibility of and Need for CHW Provision of Injectables

# Component 1

## Determine the Feasibility of and Need for CHW Provision of Injectables

CHW provision of injectable contraceptives as a CBFP strategy may have the greatest impact in areas where unmet need for family planning is high and use of modern family planning methods is low. It is therefore important to determine whether an existing CBFP program is suited for the addition of injectable contraceptives.

In addition to the guidance offered here, reference or use the Rapid Assessment Guide for Site Identification of the CHW Provision of Injectable Contraception (Appendix 1) to help determine feasibility and need.

### Assess the need for and potential success of injectable contraceptives.

The need for CHW provision of injectables depends on unmet need for family planning; demand for injectable contraception; distance women must travel to health facilities; workload of facility-based staff; access to CBFP programs such as mobile services, pharmacies, and drug shops; and diversity of the current method mix. It is important to understand who your program needs to reach by determining who is being missed by currently available services.

- Establish a core team. A core team is a small group of individuals who are interested in introducing and advocating for CHW provision of injectables. This team could be drawn from an existing family planning or reproductive health working group and would ideally include at least one MOH official.[10]

**Nurse Midwives and District Health Officers See the Need for CHW Provision of Injectables**

"Family planning needs a lot of talking to clients and yet I am always busy with deliveries, antenatal, immunization, and many other tasks. The LHWs [lay health workers, or CHWs] have really taken off a big burden from me."

—Nurse midwife,
Bulumbi Health Center, Uganda

"We don't have enough health workers to give injections. We have to encourage health-seeking behavior, and bring the services to them rather than them coming to us."

—Acting district health officer,
Nakasongola, Uganda

- Utilize the capabilities and reach of core team members to assess the feasibility of and the need for CHW provision of injectables.
- The success of adding injectables to a CBFP program will depend on several factors, including:
  - Client demand for injectable contraception
  - An existing CHW cadre that provides other family planning methods
  - Facility-based workers' experience task sharing with CHWs for other services
  - Government-level support for the practice (see Component 3 for more information)

## Identify an existing CBFP program that might benefit from the addition of injectable contraceptive services.

The questions below will help determine the relative strengths of an existing CBFP program that could support the new service. If no CBFP program exists, identify a community program to which family planning, including CHW provision of injectable contraception, can be added. Community programs to consider could include agriculture, hygiene, nutrition, or vaccination.



- Are the CHWs who are providing family planning well received in the community by clients and stakeholders?
- Will this program have a sustained presence in the area?
- Is the current CBFP program effective? For example, how many couple-years of protection (CYP) does it provide?
- Are the CHWs linked to a health facility? This is crucial for reporting, supervision, supplies, and referrals.
- Are the supervisors supportive of CHW provision of injectable contraception? Their support and engagement will lend to the program's longevity and sustainability.
- Will technical supervisors or staff members from a health facility be willing to supervise CHW provision of injectables?
- What are the qualifications of the CHWs? Do they have the basic knowledge and skills needed to learn about injectable contraception? Has the program been successfully keeping records, including records kept by the CHWs?
- Does the program have access to a reliable, consistent source of supplies, such as a clinic?
- Does the program have strong logistical support?
- Would the current program be sustainable if injectable contraceptive services were added?

## Determine how the CHWs are compensated or motivated to do the work.

- Do the CHWs volunteer?
- Do they receive payment, such as from the sale of DMPA or from a monthly stipend?
- Do they receive incentives such as rain boots, t-shirts, badges, or bicycles?
- Are the CHWs linked to income-generating activities?

### Incentivizing and Remunerating CHWs in Benin

In Benin, CHWs (known locally as relais communautaires) are volunteers who are primarily supported by local NGOs. From the NGOs, CHWs receive a community health "starter kit" containing an initial supply of medicines, including oral rehydration solution, acetaminophen, and gloves. CHWs trained in CBA2I receive five doses of DMPA-SC (i.e., Sayana Press) for free from the local health center, along with an initial supply of cotton. After that, CHWs must pay 175 CFA for each subsequent dose of DMPA-SC. They are allowed to sell each injection to clients for 200 CFA and keep the profit. CHWs also receive a transportation stipend from the local NGO to report to the health center for their monthly supportive supervision visit.

## Determine whether local health facilities support the idea of CHW provision of injectables.

- What are the CHWs' relationships with local health facilities? Try to build on any existing relationships. If these relationships do not exist, make sure to approach local health facilities early in the planning phase. Emphasize the need for their expertise and supervision. Explain that CHWs should help to reduce the workload for some services and that CHWs can reach clients who are unable to access the health facilities.

## Possible Pitfalls During Component 1

- Neglecting to establish a core team.
- Not sufficiently involving health officials at national, regional, and local levels when determining feasibility. Leadership from government at all levels is critical for establishing and maintaining support of a new service.
- Not having the product registered in-country or expecting new registration to occur quickly.
- Not engaging potential beneficiaries of CHW services, traditional leaders, or religious leaders while determining feasibility.

# Component 2

## Evaluate the Potential Costs of Adding Injectable Contraceptives to a Community-Based Family Planning Program

# Component 2

## Evaluate the Potential Costs of Adding Injectable Contraceptives to a Community-Based Family Planning Program

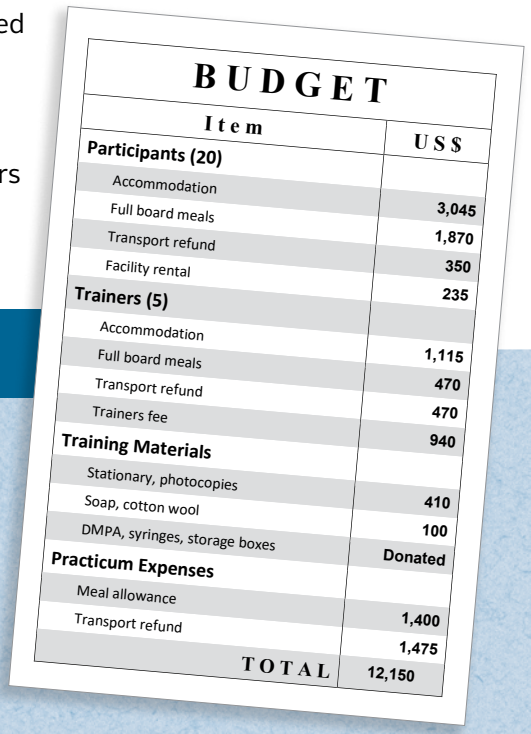
Research and economic modeling show that including injectable contraception in CBFP programs can be a cost-effective way to increase family planning use when compared with having such services available only at health facilities. Nearly 30 years of data show that contraceptive prevalence increases with each additional family planning method that becomes available to most of the population.[11,12] CBFP programs expand access to more of the population, thereby contributing to this effect.

New research shows that self-injection of DMPA may be a promising channel for reducing injectable contraception delivery costs. No major differences in costs were found between administering DMPA-SC and DMPA-IM under the same service delivery channel.[13]

To evaluate the potential cost of adding injectables to an existing CBFP program, it is important to concentrate on the additional, or "incremental," costs that the program incurs *because* of the added injectables.[14] Overall, the cost of adding injectable contraception to an existing CBFP program can be low if the program already exists, is well-resourced, and functions effectively.

### Determine the costs of introducing CHW provision of injectables.

- Training is often one of the highest expenses associated with introducing CHW provision of injectables. In addition to the trainer costs, there are expenses associated with travel, meals, supplies, equipment, training materials, and the training venue. Using trainers connected with the MOH can help forge ties between local health officials and the CBFP program.



BUDGET

| Item | US$ |
|---|---|
| **Participants (20)** | |
| Accommodation | 3,045 |
| Full board meals | 1,870 |
| Transport refund | 350 |
| Facility rental | 235 |
| **Trainers (5)** | |
| Accommodation | 1,115 |
| Full board meals | 470 |
| Transport refund | 470 |
| Trainers fee | 940 |
| **Training Materials** | |
| Stationary, photocopies | 410 |
| Soap, cotton wool | 100 |
| DMPA, syringes, storage boxes | Donated |
| **Practicum Expenses** | |
| Meal allowance | 1,400 |
| Transport refund | 1,475 |
| TOTAL | 12,150 |

**Key Costs to Consider**

- Training of trainers
- Training of CHWs
- Practicum expenses
- Supervision of CHWs
- Overall management
- Injectable commodities

- Training time can vary greatly among countries and according to the training the CHWs have completed before learning to provide DMPA. In most countries, CHWs train on DMPA in addition to any prior training. Each program determines its own training time based on local conditions and MOH requirements.
- Although DMPA may be provided free from the MOH or an NGO, commodity costs (for training and implementation) should be accounted for when estimating scale-up costs. Keep in mind that expanding provision outside of health facilities will likely result in a need for more commodities.
- In a well-resourced CBFP program, current levels of supervisory visits are likely to be adequate. Therefore, there may be little or no additional cost for supervision when adding injectables to the method mix. In new programs, supervision should be more intensive in the early stages (with longer and more frequent visits), followed by a less intensive phase of routine supervision.

## Identify funding to sustain the service.

- Will the MOH (alone or in collaboration with partners) support the provision of injectables in an existing CBFP program?
- If launched with NGO support, is there a documented plan for "handover" to a government institution?
- After CHW provision of injectables is piloted, will other organizations adopt and expand the practice with their own funding?



## Determine the costs of sustaining and scaling up the program.

- Regular supervision is the key to a strong program, and all programs should have frequent visits from supervisors to ensure that clients are being served in a timely manner with adequate counseling.
- Although training is costly, trainers and CHWs who are already trained may only need refresher trainings during initial scale-up, or their training may be sufficient for a full year. Consider when refresher training may be needed and determine the costs accordingly.
- Costs can be reduced by deploying existing trainers to scale-up areas instead of training brand new trainers, if possible. However, if the trainers have to travel extensively, this cost should be accounted for.
- Using trainers connected with the MOH can help forge ties between local health officials and the CBFP program, thereby enhancing sustainability. Usually, district or provincial health educators are engaged in the trainings.
- Be sure to take into account any programmatic changes that are made during scale-up, such as changes in training duration or in frequency of supervision visits.

### Investing in Family Planning Through Costed Implementation Plans

Many countries are progressing toward greater access to family planning through the development and implementation of costed implementation plans (CIPs). CIPs are road maps that help countries translate their family planning commitments and goals into actionable, budgeted programs and policies. CIPs typically cover a five-year period and can include aspects of family planning from contraceptive security and resource mobilization to accountability and the policy environment. CBFP can be an important component of a country's CIP. For example, Senegal's CIP prioritized CBFP, including injectables. It included plans to complete a pilot study on CBA2I and to expand the practice to all 500 functional health huts in the country. Senegal's CIP also contained plans for scaling up CBA2I by training matrons and agents de santé commaunautires (i.e., two of Senegal's cadres of CHWs) in both pills and injectables, as well as specific costs of all these activities. Other countries that have developed CIPs include Bangladesh, Benin, Burkina Faso, Côte d'Ivoire, Democratic Republic of the Congo, Guinea, Kenya, Mali, Mauritania, Niger, Nigeria, Senegal, Togo, Tanzania, Uganda, and Zambia.

- Consider the costs of compensating CHWs. Some countries provide stipends, salaries, or transport reimbursement for routine travel to health centers, while others provide material compensation such as cooking oil, raincoats, or bicycles. Will the CHWs be provided monetary compensation or other material goods that need to be factored into program costs?

## Possible Pitfalls During Component 2

- Assuming that the national health program or donors will pay for contraceptives. Even if something is free, it should be tracked as a resource to inform future scale-up.
- Assuming that scale-up costs are simply a multiplication of introduction costs.
- Neglecting to calculate the cost of training and not including refresher trainings.
- Failing to account for costs associated with program management (i.e., salaries, other personnel costs).
- Excluding M&E costs. M&E must be part of any demonstration project or scale-up effort (see Component 8 on documenting and sharing processes and outcomes).
- Not including CBFP-related costs and activities in a country's family planning budget.

# Component 3

## Integrate CHW Provision of Injectables into National Policy and Service Guidelines

# Component 3

## Integrate CHW Provision of Injectables into National Policy and Service Guidelines

Political buy-in and policy support can greatly contribute to the sustainability and success of CHW programs. In most countries, supportive policy has not been needed to start a program for CHW provision of injectables. However, policy that officially endorses CHW provision of injectable contraception helps support scale-up by ensuring that the practice is institutionalized within the health system. Efforts to update policies and align other national-level guidance, such as clinical guidelines, can be done in parallel with implementation. A common challenge is that countries often update policies and other key documents only once every five or more years. In these cases, interim solutions such as policy addendums can be issued by the MOH and later incorporated into main policies.

### Create an advocacy plan for increasing support for the practice and amending policy.

- Use a proven advocacy model to inform your plan, including identifying target audiences and influential decision makers.
- Set a specific objective that is achievable within a certain period, such as working with the MOH to outline the steps necessary to change policy or service delivery guidelines within the next six months.
- Develop activities and messages that address concerns, misconceptions, and doubts. Recognize that different stakeholder groups may have different concerns, and directly address the unique viewpoints of these groups.

**Garnering Political Support in Benin**

In Benin, aides-soignantes (a para-professional cadre of nurses' aides that provides community-based services) were already allowed to give immunizations. This helped convince policy makers that they could safely administer Noristerat, an intramuscular injectable contraceptive.

- Identify champions to support advocacy efforts. Champions are respected, influential people motivated to stimulate change. When there is opposition, champions can mobilize other key stakeholders. Consider champions at the community level, including traditional and religious leaders, who are particularly influential.
- Outline an approach for engaging different stakeholders. Plan a one-on-one meeting between a champion and a key stakeholder, make a presentation at a relevant

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technical working group meeting, have an informal discussion over lunch, hold a technical consultation, or conduct educational tours for South-to-South learning.

## Advocate for policy change to endorse CHW provision of injectables.

Generating support at the national level is necessary to influence changes in health policy and service delivery guidelines, and to garner financial support.

- Determine whether national policy or service delivery guidelines already support community-level workers to administer injections of any kind.
- Engage a wide range of stakeholders, including ministry officials (especially those in sexual and reproductive health, family health, or community services departments); relevant national technical working groups; health worker training schools; professional health associations in medicine, nursing, and midwifery; relevant NGOs and community-based organizations; institutions; donors; and other partners.
- Present information on the practice at regular technical working group meetings and speak to stakeholders one-on-one. These forums give stakeholders an opportunity to have their questions answered with evidence. Prepare for these meetings by developing talking points on the benefits of the practice, how it has been used successfully in other countries, and available in-country evidence.
- Support champions from the local level (including representatives from civil society, the faith community, and health facilities) to engage national-level decision makers by expressing their support and desire for the practice in their communities.
- South-to-South exchanges, in which countries (or communities within the same country) share knowledge and experience virtually or through in-person study tours, are particularly important for experiential learning. Such exchanges have been key in adoption of the practice. Study tours are most productive when they are action-oriented with adequate support for follow-up and change management.
  - In Senegal, early involvement of regional health authorities helped build support for the project. Project coordinators approached regional health offices to request permission to conduct the pilot project and support regional coordination meetings with the national steering committee.
  - The Uganda MOH hosted study tours for country delegations from Kenya, Malawi, Nigeria, and Rwanda to share lessons learned on the practice after Uganda's successful pilot. All four countries changed policy to support CHW provision of injectables.

- Malawi's community-based access to injectable contraception project started with an 18-month pilot in 2008, initiated after a team from Malawi visited Madagascar to understand how its program had been implemented.
- A Beninese delegation was hosted by the Burkina Faso MOH for a study tour to share lessons learned in introducing DMPA-SC at the community level. The study tour provided enough evidence for the Beninese MOH to pilot introduction of DMPA-SC in 10 health zones.

> "It all starts with convincing one key person, who will be the catalyst [for change]."
>
> —Former head of the Reproductive Health Division, Uganda MOH

- Sustained and varied efforts are needed to continuously engage and cultivate supportive colleagues and address opposition. Be prepared to continue advocacy over time and to adapt to any changes in the political landscape (e.g., elections leading to a change in ministry personnel).
- Monitor advocacy activities and track which team members conducted which activities. Also note the success rate of these activities and learn from any challenges faced.
- Be aware that individual relationships are critical for successful advocacy. Cultivate rapport and collaborative relationships with key stakeholders, and be prepared to sustain them over time.

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## Align other national guidance documents to support CHW provision of injectables after the national policy is changed or updated.

Once the MOH and stakeholders agree to support CHW provision of injectables, additional documents may need to be amended.

- **Clinical protocols and guidelines:** Ensure that guidelines do not contain medical barriers to family planning provision at the community level. Barriers may include requiring blood pressure measurements or physical exams before the provision of family planning. These tests are not needed for safe provision of injectable contraceptives, and CHWs can determine a client's medical eligibility by using a question-based checklist endorsed by the MOH.[15]

- **Regulatory policies:** Be aware that some policies may present additional barriers and require advocacy to change. For example, identify possible restrictions on youth accessing family planning services and decide if an advocacy campaign is needed to change them.
- **Family planning training curricula and materials:** Ensure that training guides and job aids are available for CHWs and their supervisors and that they are updated to include content on injectable contraception.
- **Supervision models:** Ensure that guidelines include regular supportive supervision for CHWs who provide injectable contraception.
- **Logistics and supply chain management plans:** Make certain that injectable contraceptives will reach the community level, that CHWs contribute data to inform the plans, and that a resupply mechanism is in place.
- **Record-keeping systems and health management information systems (HMIS):** Ensure that reporting forms for CHWs are simple and available, and that a mechanism exists to channel community-level information to the broader HMIS.
- **Family planning CIPs:** Confirm that funds are allocated for training and supervision of CHWs.
- **Community health policies:** Make sure that policies reflect new services offered by CHWs and specify the selection criteria for CHWs who provide injectable contraceptives.[16]

## Country Experiences with Changing Policy

Uganda was the first known African country to pilot CHW provision of injectables, achieving policy change in 2010—more than five years after the pilot project. After the pilot, officials required additional evidence on the feasibility of this practice within the public sector, so implementers expanded service provision to additional districts with government-run CBFP programs and monitored it closely. Years of evidence from across the country demonstrating that the practice was not only safe but also feasible was used by several stakeholders within and outside the MOH to successfully advocate for policy change. The former head of the MOH's Reproductive Health Division in Uganda said, "Regarding CBD [community-based distribution] of DMPA, we felt we had to get the experience before changing the policy. After testing it in Nakasongola, Nakaseke, and Luwero, we should have enough experience to change the policy."

In Nigeria, support for policy change came after a study tour to Uganda and consistent advocacy with the MOH. The 2012 London Summit on Family Planning also contributed to the creation of a policy on CHW provision of injectables in Nigeria, when the Honorable Minister of Health committed to "train our frontline health workers to deliver a range of contraceptives."[17]

In Kenya, strategic and intense advocacy with professional organizations that had originally opposed CHW provision of injectables, such as nurses and midwives associations, eventually resulted in these constituents contributing to the successful campaign for policy change and to commitments made in 2012 to scale up the practice.

### Building Local Support for CHW Provision of Injectable Contraception

Before the Uganda pilot project began, health officials at national and district levels were hesitant about nonmedical personnel giving injections. "The idea of [CHWs] giving injections was considered radical. I was really very skeptical about it," said a former acting district health officer for Nakasongola district. "It was hard to see someone without training in medical ethics or safety giving injections. But then I saw there were no problems. The fact that there were [CHWs] successfully giving immunizations helped. Let us speed up the process of offering DMPA. . . . It would be good to expand it to every part of Uganda."

## Obtain a waiver or written permission from the MOH for temporary CHW provision of injectables during the interim when policy has not changed.

Policy change takes time. This means that there may be a gap between when a project is introduced and when policy is changed to allow the practice. This can pose a challenge for continuing to serve clients who received family planning services during a demonstration project. Countries that experienced this were able to obtain permission from the MOH to continue service provision in the project area until policy changed. Permission may be officially granted in the form of a waiver, memo, circular, addendum, or similar document. Ensure that this permission is communicated with local health officials and shared with health facility staff and others involved in implementation so that everyone is aware that they can continue CHW services.

## Possible Pitfalls During Component 3

- Assuming that the absence of national regulations and service delivery guidelines for CHW provision of injectables rules out the possibility of starting or scaling up a program.
- Assuming a country wants or needs to choose both intramuscular and subcutaneous injectables.
- Not amending clinical guidelines that can create barriers to the provision of injectables.
- Not writing policy in clear language that specifies the range of family planning services that CHWs can provide. If the policy guidance simply says a method is provided "at the community level" without listing the cadres of providers able to administer that method, confusion could ensue. In many countries, multiple providers work at the community level, including auxiliary nurses, midwives, and outreach teams, which can even include doctors.
- Neglecting to establish a core resource team and invest in champions who are needed to build political will and advocate over a sustained period.

# Component 4

## Mobilize the Community and Raise Awareness of the Service

ALICE OLAWO, FHI 360

# Component 4

## Mobilize the Community and Raise Awareness of the Service

Community mobilization and demand generation are critical components of CBFP programs. These activities forge a connection to local stakeholders and beneficiaries, introduce the service and trained CHWs to communities, generate demand for health services, and educate the community on family planning and the services that CHWs can provide. Such activities also ensure that men, local leaders, and youth are engaged in the health activities in their own communities.[18] Engaging potential clients and providers in the design of the program can be linked with community mobilization. This helps answer how to offer services that meet clients' needs and expectations. Community involvement can lead to improved outcomes by:

- Increasing community demand for family planning.
- Increasing ownership, support, and responsibility for implementing activities.
- Fostering an enabling environment that helps people adopt and sustain new behaviors. People are more likely to sustain and improve health-related activities if they are active contributors.

### Develop a plan for conducting community-level mobilization and raising awareness before CBA2I is introduced.

- Solicit input from local opinion leaders and district health teams when developing your plan.
- Employ a social and behavioral change communication approach that outlines both your intended audience, such as youth and adolescents or men, and how you will reach them. Consider partnering with a communications specialist.
- Create a process for monitoring and evaluating promotion and awareness activities and allow for adjustments in your plan as needed.

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### Coordinate and convene regular meetings to engage local leaders and conduct community sensitization activities to promote the new service before, during, and after CBA2I is introduced.

- Meet with local leaders to discuss sensitization activities, solicit input, and gain support and buy-in. Local leaders can provide valuable information about potential barriers to family planning uptake within their communities that can be addressed through sensitization efforts.

- Community sensitization activities can range from simple gatherings to community drama events. The most important element of the activities is ensuring that CBA2I information is presented accurately and tailored to the specific needs and customs of the community.
    - In Madagascar, project coordinators convened community meetings with mayors, village chiefs, and other leaders to generate support for CHW provision of injectables. Coordinators made an official presentation at community health facilities. Newly trained CHWs received an official certificate from the MOH, and they were introduced to their communities by the mayors, village chiefs, and supervisors. Word of mouth among clients also helped generate demand. This approach to community engagement has been successfully replicated in other countries, including Rwanda, Kenya, Uganda, and Zambia.

## Sensitize health facility staff to gain buy-in for the service.

- Ensure that facility-based staff understand the value of their role in supporting community-based services. They serve as supervisors and mentors and provide higher-level medical care that CHWs are not equipped to offer.
- Be prepared to answer questions about task sharing. Clarify that the CHWs are providing services that complement—but do not replace—the services provided at the health facility. Also address any concerns about CHWs that may arise.
    - In Senegal, project coordinators worked to secure commitment from the directors of community health facilities. The project coordinators officially presented the project at community health facilities and held community meetings to introduce CHWs. The directors were hesitant in the beginning, but they are now committed to supporting the project.

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## Identify and engage community-level champions.

- Reach out to key influential groups such as traditional and religious leaders. Recognize that they, in addition to men in the community, are often gatekeepers and key decision makers. Work with them to promote family planning in their communities and secure their commitment to support the service.
    - In northern Nigeria—a region strongly influenced by religion—the introduction of CBA2I gave special attention to religious leaders as the first and most important group to be informed and sensitized about the service. In turn, they encouraged the new service and were instrumental to the success of the project.[19]

## Produce and disseminate advocacy materials, such as leaflets and posters, about injectable contraception.

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- For literate and semiliterate populations, leaflets (distributed at local health facilities, community meetings, and other gathering places) and posters (displayed in health facilities, municipal buildings, and marketplaces) may attract community attention and support for family planning. Involving community members in the development of such materials is essential.
    - In Uganda, a senior health educator was involved in developing a printed advocacy kit to garner support for expansion of the service. She said, "[Local] stakeholders have had a hand in development of materials…this helped allay fears and concerns. Openness in developing materials has been helpful, especially involving community leaders. Their involvement and acceptance help others jump on the bandwagon."

## If possible, conduct a mass media or social media campaign.

- Mass media campaigns could consist of radio or television spots that advertise the availability of injectable contraception through CHWs in the target area. Social media campaigns could consist of Twitter chats or Facebook advertisements that inform potential clients about available services. Consider what proportion of your target population has access to radio or television, and which social media platforms your target platform currently uses, before undertaking such a campaign.
    - Radio spots in Madagascar attracted clients to community health facilities, helping distributors complete their practical training, which included administering six injections.

### Impact of Advertising Through the Media

Community members in Uganda, including women using Sayana Press, were most likely to report hearing about the new product from radio or village health teams (VHTs). As one young woman in Apac district reported, "I started using Sayana Press after hearing about it from Voice of Lango FM… I have used it for nine months now." At the same time, VHTs clearly played a critical role. Another youth in Kyegegwa district shared, "The VHTs have made tremendous efforts to meet people in their youth groups during meetings, and sometimes having a one-on-one session to talk about family planning."

### Mobilization and Sensitization: A Community Leaders' Role

In the Luwero district of Uganda, the local secretary of health was selected by the community as the family planning advocate and was instrumental in bringing CBA2I to the district. A popular leader and a Catholic, he strongly believed in the need to limit family size. According to him, "As leaders, we should try to help our people understand the link between their quality of life and the size of their families, and then lobby for support for family planning from the government and donors."

- A member of Parliament in Uganda said that sensitization is particularly needed regarding male involvement in family planning. He recalled a successful national radio campaign that encouraged men to see the benefits of smaller families by using humor to compare the difficult life of one man who had not used family planning and had many children, with the life of another man who had a small, manageable family.[20]

## Possible Pitfalls During Component 4

- Neglecting to generate local-level support for CHW provision of injectable contraception before launching a program.
- Not engaging your audience to develop tailored advocacy messages to meet their needs.
- Assuming community leaders will not be supportive, and avoiding engaging them in advocacy efforts.
- Assuming that men and boys are uninterested in knowing about or being involved in family planning discussions.
- Neglecting to commence a mass media or communication campaign alongside the introduction of the practice.

"The pilot study was a good idea... Family planning helps families to ensure spacing so that children grow healthy and are able to go to school. It is good that women are able to access the family planning services within their villages."

—His Royal Highness, Chief Mphuka, Luangwa, Zambia

# Component 5

## Ensure a Logistical System that Supports Proper Waste Management and a Steady Provision of Supplies

# Component 5

## Ensure a Logistical System that Supports Proper Waste Management and a Steady Provision of Supplies

A sound, logistical system ensures that contraceptive commodities and other supplies are distributed in the correct amount, in good condition, and on time. In particular, getting health commodities down to the very "last mile" can be particularly challenging for many CBFP programs, so supply chain management is a priority.

### Considerations for Registering a New Method

With a contraceptive method that is new to a country's method mix, such as DMPA-SC, anticipate the activities and investment needed to register the method. Have the method included in a national-level supply chain and be distributed through CBFP programs. Privately funded supply chains can exist in parallel to the national distribution system and may be less prone to stock outs. They may be useful in some situations, like initial start-up or extenuating circumstances, but they are not a sustainable solution.

### Identify and map an existing system that will reliably support logistics for CHWs.

Most countries have established systems—typically linked with the MOH—that provide access to medical supplies.

- Work within an established contraceptive logistics management system that also incorporates waste management, to procure and distribute contraceptives and related supplies. Ideally, the logistics system is already supporting the CBFP program with condoms and oral contraceptives.
- The logistics system may function through the MOH, an NGO, or a combination of agencies. To maintain a well-functioning system, the project will need to develop a collaborative relationship among the CHWs, their supervisors, and the other local health facility staff.
- If an NGO is supporting a demonstration or scale-up project for CHW provision of injectables, the ultimate goal is to install the project in the public-sector system for sustainability. In the interim, supplies may be temporarily provided through the NGO.
- It is important to distinguish program outcomes by disaggregating community-based services from clinic-based services. To show trends in method usage and service delivery, record-keeping tools (e.g., registers, stock cards, logistics management information systems, HMIS) need to be updated to include all injectables being offered and the provider category, including self-injection where applicable.

## Identify the people in charge of the logistics system.

- Identify and build relationships with people at the national level and in the project's locale who coordinate the supply of commodities and supplies. Discuss how commodities are distributed to health facilities at all levels and how they will be systematically provided to CHWs.
    - In Uganda, the district health officer is responsible for overall logistics management for the district. Within a community health facility, the officers in charge or the maternity unit dispensary may be responsible for providing supplies to CHWs. Other community-level logistics managers may include midwives, clinical officers, and health facility directors.
    - In Madagascar, NGOs help monitor and reinforce national logistical systems. If there is a stock out or supply problem, NGOs can help resolve the problem and work with the government to develop a more sustainable solution.
    - In Benin's DMPA-SC introduction, it took several months to clarify and reinforce who was responsible for resupply for CHWs, and who was responsible for tracking consumption patterns. Early agreement or written terms of reference can help avoid delays.
- Sensitize and involve logistics managers at the national and local levels to prevent and resolve logistics problems, such as unreliable transportation, stock outs, and lack of storage, that affect CHW provision of injectables.
- Bring key people together face-to-face to develop a contingency plan with activities to remedy stock outs in the short term. Capture the plan in writing and share it among relevant stakeholders to build a common understanding.

## Connect CHWs to health facilities for commodities, supplies, and guidance on proper waste management.

Depending on the CHWs' background and experience with the existing CBFP program, they may already be familiar with the government or NGO logistics management system and the health facility staff. Project coordinators will need to help strengthen the collaborative relationship among the CHWs, their supervisors, and the health facility staff for the best management of logistics and waste.

- Identify existing waste management systems and procedures, or plan to ensure that they are in place for CHWs and their associated facilities.
- Make close links with health facilities to help ensure that CHWs have a reliable supply of family planning commodities to avoid stock outs.
- Ask logistics managers to consider the frequency of their visits to CHWs (or vice versa in the case of CHWs picking up supplies) and the quantity of commodities resupplied. Ensure that a schedule for waste management is integrated into other processes such as supervision meetings or supply pickup.
- Hold discussions with facility staff during regular staff meetings about CHWs' supplies and waste management duties. Try to address any weaknesses in the system before the practice of CHW provision of injectables is scaled up.
- Provide CHWs with training about logistics, the disposal of sharps, and other waste management concerns. During the training, they will need to receive an approved

and sturdy container for sharps, information about how to dispose of the sharps container and other waste, and information about how to request and receive new boxes. More information on CHW training is provided in Component 6.

**Managing Sharps Containers**

When the sharps container is about three-quarters full, CHWs return the container to their supervisor or the health care facility and get a new one. Replacing the container at this stage prevents a provider from trying to put a needle and syringe into a container that is already full, and thus prevents needle sticks. Local regulations on waste management should be followed to ensure the health and safety of all members of the community.

## Procure sufficient stocks of all supplies.

- Avoid stock outs with forecasting and consideration of the context in which CHWs work. Forecasting should consider special circumstances such as travel barriers, weather patterns (e.g., the rainy season), advance supplies, and supplies for training and practice. Procuring buffer stock (e.g., so that CHWs or self-injecting clients have multiple months of supplies) can help avoid stock outs.
- Provide CHWs with either DMPA or NET-EN because reinjection schedules can differ. DMPA-IM and DMPA-SC can be introduced in parallel because they have the same reinjection schedule.
- Instruct CHWs to share supplies with other trained CHWs when unforeseen challenges arise.
- In countries implementing CHW provision of injectables, it is standard practice for the CHWs to submit monthly service reports to community health facilities. This ensures regular contact with the facility's staff and allows the CHWs to get more supplies. The clinic staff members also supervise the CHWs.

## Ensure timely submissions of supply orders.

Submitting supply orders at regular intervals (and requesting sufficient supplies) helps avoid stock outs. This can be challenging because CHWs, community health facilities, and district health offices all need to submit their requests in a timely manner for supply chain management to function smoothly.

- Ensure that all the order forms include all the methods and supplies for practice injections, when applicable.
- Track distribution and estimate future stock needs. This allows monitoring of service reach and uptake and midcourse changes to supply orders (see Component 7 on establishing systems for supportive supervision and Component 8 on documenting and sharing processes and outcomes).
- All CHW forms for tracking commodities should be field-tested with CHWs to ensure that the forms are clear and easy to understand. If modifications must be made to simplify the forms, seek input from health facility staff to ensure that the new forms still provide the information they require for logistics management.

### Managing Supplies in Liberia and Uganda

Distributors in Liberia began their work with 30 doses of DMPA, 30 syringes, a small bottle of alcohol, 50 grams of cotton, one safety box, monitoring tools, reporting forms, job aids, a CHW guide flip-book, and a backpack in which to store and transport the supplies. In Uganda, start-up supplies were similar, but CHWs received a wooden chest in which to store their supplies and rain boots. While consistent government management of these supplies is uncertain, such items have been provided by the NGO supporting the CBA2I program.

- It is common for CHWs to submit monthly service reports to community health facilities. This ensures regular contact with the facility's staff and allows the CHWs to get more supplies and return waste. The clinic staff members also supervise the CHWs.
- Regular supervision visits are an opportunity for coordinators to reinforce concepts about the logistics system and to bolster the skills of the new service providers (see Component 7 for more guidance on supervision).

## Ensure proper storage of injectable contraceptives.

A sturdy container—lockable, if possible, and made of metal or wood—protects injectable contraceptives and syringes and keeps them inaccessible to children and animals.

- DMPA should be stored upright, away from direct sunlight, out of reach of children and animals, and at a temperature no higher than 25 degrees Celsius but above freezing. DMPA-IM should be used within its five-year shelf life and DMPA-SC within its three-year shelf life. DMPA-SC foil pouches should be opened only when the injection is given.

## Possible Pitfalls During Component 5

- Not defining or clearly cultivating the relationships between the CHWs and the local health facilities with respect to the supply of commodities and waste management.
- Failing to establish a system (or add to an existing system) for submitting supply orders in a timely fashion, resulting in stock outs. Orders need to be submitted from CHWs to local health facilities, from local health facilities to district health offices, and from district health offices to national health programs.
- Not taking into account all supplies needed for CHW training, practicum, and the new service (e.g., cotton, sharps boxes, soap and water, DMPA-IM, DMPA-SC, training surrogate for potential self-injectors to practice on [a condom filled with sugar or salt]).
- Assuming CHWs will be able to forecast or request commodities before they have practiced how to do so for a couple months.
- Failing to ensure that supervisors routinely check in with CHWs about ordering stock and about proper waste management practices.
- Consolidating community-based facility data, which would prohibit tracking the impact of each provider category.

# Component 6

## Train Community Health Workers to Provide the Service

SIGA DIOP, FHI 360

# Component 6

## Train Community Health Workers to Provide the Service

The success of a CHW provision of injectable contraception program depends in large part on the knowledge and skills of CHWs. Effective training ensures that CHWs have the competencies they need to deliver quality family planning services. Many demonstration projects have adapted FHI 360's materials to develop country-specific trainings, including those in Benin, Liberia, Senegal, Uganda, and Zambia. A CHW training curriculum and materials, such as job aids and checklists for CHWs, are available for program managers to adapt (see Appendices 2-5). A CBA2I curriculum for drug shop operators can be found at https://www.k4health.org/toolkits/communitybasedfp/drug-shop-operators-training-materials. A DMPA-SC curriculum can be found at https://www.path.org/articles/dmpa-sc-training/.

### Identify competent people who have the potential to provide high-quality family planning services.

It is important to have clear, written criteria for selecting distributors to provide injectable contraception. Together with stakeholders, project coordinators should:

- Develop criteria for selecting the CHWs, including a way to ensure adequate geographic coverage
- Select CBA2I providers using an approach that involves the communities and district health management team

## CHW Selection Criteria : Zambia, Pakistan, and Rwanda

| Zambia | Pakistan | Rwanda |
|---|---|---|
| Resides in his/her catchment area | Female | Between 20 and 50 years of age |
| Willing to serve as a volunteer | Between 18 and 50 years of age | Able to read and write |
| Is a good mobilizer and communicator | Resides in and recommended by the communities she serves | Willing to volunteer |
| Able to read and write in English and have completed at least grade 9 | Is preferably married, with child(ren) | Considered by peers to be honest, reliable, and trustworthy |
| Has already been trained in the provision of condoms and oral contraceptive pills | Is willing to work out of her home | Elected by village members |
| Is exemplary, honest, trustworthy, and respected | Has a minimum of 8 years of education | |
| Between 25 and 45 years of age | | |

## Identify a training curriculum and job aids for the CHWs.

- Assess the CHWs' training needs to understand their experiences, knowledge, skills, and literacy levels. This information will inform the selection or adaptation of a curriculum and help avoid spending valuable time teaching material CHWs already know.
  - Most curricula provide a brief review of family planning and then focus the majority of the training on safe injection techniques and detailed information on injectable contraception. If the CHWs need more than a refresher on family planning, include a separate family planning module in the CHW training.
  - Some countries, such as Malawi, are introducing DMPA-SC by provider and self-injection simultaneously. DMPA-SC is becoming a popular method for provision by CHWs, but there is no reason that countries should not simultaneously promote self-injection with DMPA-SC (a practice that can be rolled out through both clinic-based and community-based services).
- Use government-approved, nationally validated curricula and job aids if available. If not available, then adapt an existing curriculum with involvement from a variety of stakeholders, including the MOH. The materials selected should have been field-tested to ensure that the concepts will be understood by CHWs with similar skill levels.
- Include content on balanced counseling and related material to equip CHWs with the knowledge and skills needed to counsel on the whole range of family planning methods, even ones that require referral to a clinician.

- Ensure that training focuses on the goal of CHWs becoming competent in necessary skills instead of simply obtaining knowledge. Also ensure that the training is evidence-based, reflects the most recent WHO medical eligibility criteria for contraceptive use, and meets the approval of the MOH.
- Translate materials into the local language if necessary.

## Procure the relevant training materials.

- Visual aids, such as posters displaying all family planning methods; samples of family planning methods; and calendars, client tracking cards, and referral cards can be procured.
- Job aids on ruling out pregnancy, initiating pills and injectable contraception, applying standards for the provision of counseling, and giving injections (see Appendix 4 or https://www.k4health.org/toolkits/cba2i/job-aids) are other examples of possible training materials.

## Mobilize clients interested in receiving injectables for the practicum.

- As discussed in Component 4, effective community mobilization and sensitization about family planning methods will increase the number of people seeking services. Practicum sessions should be arranged at health facilities so that CHWs can practice counseling and administering injections with real clients.

### Training CHWs with Low Literacy

In Liberia and Senegal, existing CHWs and matrones were selected to provide injectable contraception. While all of the CHWs met the established criteria, such as being well-respected in their communities, a few had low levels of literacy in both reading and writing. These CHWs were given extra attention during the training and were assisted by fellow CHWs to commit concepts and practices to memory based on the pictorial guidance provided alongside the written instructions. Given their experience providing other health services, these CHWs with basic reading skills were able to write the basic information required, such as clients' names and return dates. The trainings included many days of a practicum, during which the CHWs demonstrated their counseling and injection skills. Some of these CHWs with low literacy were among the best counselors and helped the trainers by providing advice to other CHWs during the practicum.

## Identify and orient competent trainers.

- Local or national health offices should be able to provide master trainers who typically conduct trainings on family planning and other health topics in the country. Master trainers should be knowledgeable about adult learning principles and family planning and should be adept at teaching health workers how to provide injectables.
- If an NGO is conducting the demonstration project, government trainers and health staff should still be included in the training in some way. Integrating a new practice like CHW provision of injectable contraception into the existing MOH structure in small but concrete ways lays a firm foundation for future sustainable scale-up and creates ownership for the practice.
- Provide the trainers as well as the CHWs' supervisors with an orientation on community-based services and review the CHW training curriculum, schedule, and roles before training begins.
    - Discuss early with supervisors the critical role they play in ensuring the CHWs' success.
    - Including supervisors and local stakeholders in the training strengthens buy-in and increases their support for introducing and scaling up CBA2I.

## Conduct the training.

- Follow the MOH's recommendations on training, as well as the curriculum you have adapted or created.
- Training length will depend on the number of topics and the depth of information covered (see Appendix 2 and the text box "Two Training Models").
- Keep the training class small. Ideally, the class should not exceed 20 CHWs. A class with too many participants is unlikely to help them achieve competency in the skills they need.
- Engage the CHWs and their supervisors in the training so that they are oriented and aware of the program from the start and are able to practice supervision.
- Bring in a panel of experts who represent different points of referral for clients who select long-acting reversible contraception and permanent methods or need support managing side effects.
- Include practicum training on counseling and giving injections.
    - CHWs will role-play counseling with other CHWs who pose as clients and will learn to inject by practicing on an injection model or simple substitute, such as a loaf of bread or a condom filled with salt or sugar. They will also need to practice with actual clients during the practicum.
    - CHWs are required to provide a specific number of supervised injections to people during a training period, as approved by the MOH. The number of required injections is around five for most practicum sessions. Ideally, training

is conducted at CHWs' respective health facilities. This approach has the additional benefit of developing the relationship between CHWs and the health workers who supervise them. If a CHW is already providing DMPA-IM injections and the program is introducing DMPA-SC, the practicum requirement may be reduced.

- Skills such as ruling out pregnancy, calculating a reinjection date, and drawing the solution from the vial may require special attention.
- The importance of proper and comprehensive client counseling, including counseling on side effects, should be emphasized. In particular, clients using injectables may experience side effects and are more likely to continue the method if they are properly counseled with complete and accurate information.[21-25]

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- Incorporate a graduation ceremony into your training and introduce the CHWs to their community. This will enable the community to know who the CHWs are and what services they provide. Graduation ceremonies also contribute to the motivation of CHWs. Recognition by the community is a major motivator.[26]

## Two Training Models

Depending on client demand, it may take two to four weeks for CHWs to complete their "practicum phase." Benin began with a practicum period of two weeks and has since expanded it to four weeks. If a CHW isn't successfully certified during the allotted time, he or she can serve in a promotional role for family planning.

In Kenya, a training for CHW provision of injectables contraception lasted for three weeks. During the first week, training took place in the classroom, mostly for theoretical training. Trainers discussed community mobilization, health education, counseling, logistics management, and record keeping. The CHWs practiced their injection techniques on tomatoes and oranges at the end of the first week, and they learned how to properly dispose of used needles. The second and third weeks involved practical training at district health facilities under the supervision of medical personnel. The last three days of this period were spent in selected health facilities closer to the CHWs' community where, under close supervision, they provided services to clients.

## Support CHWs to gain skills in referrals and record keeping.

- Ensure that CHWs understand referral activities that include:
  - Following up with clients about side effects and other concerns
  - Referring clients to the health center for long-acting and permanent family planning methods
  - Following up with clients after referral for long-acting and permanent family planning methods
- Ensure that facility-based staff, including supervisors, are aware of the CHWs' roles in referring and keeping records. Including supervisors in the CHW training and establishing strong linkages between the CHWs and facilities will help develop working relationships and facilitate referral and record-keeping processes.
- Instruct CHWs and health facilities to refer clients to each other.
  - Health facilities should refer clients to CHWs when clients live too far away to access the facilities regularly, or when the facilities do not have time to provide family planning methods or to promote the new service.
  - CHWs should refer clients to community health facilities if there is a problem with the injection site, when clients are experiencing side effects or new problems that may require medical attention, or when clients need or request a long-acting and permanent family planning method that the CHWs cannot provide (e.g., an intrauterine device).
- Throughout the training, but particularly during the practice sessions, emphasize the importance of keeping good records and completing forms. CHWs should follow a regular schedule of submitting their statistics to project managers. Keeping records, documenting processes, and sharing outcomes are discussed more in Component 8.

### Community-Based Referrals: Which Model Works Best?

Evidence on referrals, especially at the community-level, is limited, and details about how referrals are made are often absent in the literature. A recent literature review sought to synthesize evidence on different referral models that would be relevant to CBFP, and to provide programmatic guidance on the most promising models. The review focused on referrals that directed clients from community-based services to facilities, for services that were not offered by a community-based provider. It looked at various kinds of verbal referrals, paper-based referrals, paper-based referrals with a follow-up mechanism, facilitated referrals, and referrals made using mobile phones. The literature review found that of all the models, referrals based on mobile phones were the most promising for current and future programs because they are versatile, are adaptable, and offer other benefits such as real-time data reporting. No matter what the referral mechanism is, however, strong linkages between community-based providers and facilities will be key to ensuring a well-functioning referral system.[27]

### Progestogen-Only Injectables and HIV Acquisition

In 2017, WHO issued revised guidance for women at risk of acquiring HIV. The recommendation is that "progestogen-only injectables (norethisterone enanthate [NET-EN] and depot medroxyprogesterone acetate [DMPA, intramuscular or subcutaneous]) can be used by women at high risk of HIV, because the advantages of these methods generally outweigh the possible, but unproven, increased risk of HIV acquisition."[28]



## Evaluate all training.

- Survey the CHWs after the training to elicit their comments on the trainers, the curriculum, the materials, the injection practice, and their confidence in providing injectable contraception.
- Observe the CHWs as they give injections and counsel clients about family planning.
- Monitor the CHWs in the weeks and months after the training to see how well they retain the knowledge and skills they gained during the training.
- Review the CHWs' reports and registers.

### Refresher Training in Uganda

Some officials in Uganda feared that the program expected too much from the CHWs. The Uganda program decided to hold refresher trainings to keep the CHWs' skills sharp. These refresher trainings were short courses to reinforce the CHWs' previously acquired knowledge and skills. The training provided CHWs with new information about family planning methods, a forum to share lessons learned with other CHWs, and a source of professional development. A CHW in Kiyanja village, Nakasongola district, said she gained more skills from the refresher training and that it inspired her to continue her work.

## Possible Pitfalls During Component 6

- Not adapting existing curricula to country-specific needs and instead creating new training tools.
- Failing to secure all of the materials that CHWs require for the practicum and for immediate use after the training, including counseling tools for family planning, reporting forms, family planning registers, other job aids, and commodities and supplies.
- Neglecting to mobilize clients for the CHWs' injection practice sessions during the practicum.
- Assuming that the initial training will be adequate. Refresher trainings may be needed to reinforce key messages and help the CHWs maintain knowledge and skills. Refresher trainings can be formally organized for groups of CHWs or conducted informally through one-on-one supportive supervision meetings.
- Not engaging CHW supervisors and the district health office in training and supervision.

> "Before the pilot, we did not provide family planning services. With the training, I have been able to provide women in my community family planning services including injectable contraceptives."
>
> —CHEW in Nigeria who sees 15 to 20 clients a month at homes in Gombe state where the pilot was held—an area that has traditionally been hesitant to embrace family planning

# Component 7

## Establish Systems for Supportive Supervision

# Component 7

## Establish Systems for Supportive Supervision

Effective supervision supports the performance of CHWs and the overall quality of your CBFP program. When supportive supervision is used, it not only monitors and assists the community-based providers but also provides an opportunity to build their skills and connections at local health facilities, address challenges they may be experiencing, and provide valuable mentorship.

### Provide supportive supervision on a consistent schedule.

Supportive supervision is more than a simple check-in or review of service delivery statistics. It is a system of two-way communication that promotes self-improvement and high standards for program quality.[29]

- Ensure that supervisors are trained and available to provide supportive supervision to CHWs at the field level. This may involve regular visits or the provision of staff at the district or subdistrict level, if feasible, to assist CHWs as needed and to ensure high-quality services.
- Train supervisors on the use of supervision checklists that, at a minimum, include questions on counseling, referrals, injection technique, waste disposal, and commodity supply (see Appendix 5).
- Establish a supervision schedule that will allow supervisors and their CHWs the time and opportunity for supportive supervision.
- Convene regular meetings of CHWs, supervisors, and health facility staff to discuss safety, quality, logistics, and any other relevant issues. This is especially important during the first six months of implementation to ensure that the program is fully established.
- Aim to prevent any logistical challenges that may hamper supervisors' ability to meet with CHWs in their villages, such as lack of transport or fuel. Programs may consider providing bicycles or a small stipend to cover transport within the catchment area.

**Example Supervision Schedule**

**Monthly:**

Check registers, compile data, discuss challenges, resupply methods

**Quarterly:**

Observe service provision

**Spot checks:**

Make unannounced visits to CHW's sites to ensure high-quality services

- Identify the types of supportive supervision already in place within the NGOs and the district health offices. Can community-based provision of injectables be easily incorporated into the existing supervisory systems?
- Conduct supervision meetings. Consider creative solutions for supervision, such as peer supervision by experienced CHWs or group supervision meetings in locales such as meeting spots in the community.
    - In Zambia and Benin, supervisors are included as participants in part of the CHWs' training. They meet the CHWs and gain a solid understanding of their role as supervisors. In Benin, the supervisors serve as trainers in a cascade training model after completing a 2.5-day training of trainers that includes theory, practice, and guidance on how to be an effective trainer.

## Conduct an on-site evaluation of trained CHWs shortly after they complete their training.

The first supervision visit should take place soon after CHWs begin providing injectable contraceptives, ideally within two to four weeks of training. This timing will ensure that the CHWs are providing both correct information about family planning and safe injections to their clients.

- Supervisors—from district health offices or partner NGOs—should evaluate the performance of the CHWs on a monthly or quarterly basis, or more frequently for new CHWs.
- Evaluations should focus on the following questions:
    - Are CHWs providing clients with complete and accurate information about family planning, including using job aids and counseling on all methods, on potential side effects, and on the need for dual protection against HIV and sexually transmitted infections?
    - Are CHWs using their pregnancy screening checklists, and using them correctly?
    - Are CHWs correctly determining whether clients are eligible for injectable contraceptives?
    - Are CHWs filling out forms and registers correctly? Do they have enough copies of blank forms and pencils?
    - Are CHWs using calendars correctly to determine reinjection dates?
    - Are CHWs administering injections or training women on self-injection properly?
    - Are CHWs disposing of waste appropriately?

ALICE OLAWO, FHI 360

### Supervision of Lady Health Workers in Pakistan

In Pakistan, lady health workers (the national term for CHWs) form a substantial and important part of the national health workforce. Numbering more than 100,000, they provide primary health services to more than one-half of Pakistan's rural population. Lady health workers are supervised by lady health worker supervisors, who are health facility staff from the same residential area as the lady health workers they supervise. The supervisors typically oversee 20 to 30 lady health workers and are responsible for conducting monthly meetings with the workers in their catchment areas. During these visits, the supervisors complete a monthly work plan, review the previous month's plan, and fill out a performance review card on the lady health workers they are visiting. These reports are then submitted to the district, where they are compiled and submitted to the province, and then up to the federal level.[30]

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  - Do CHWs refer their clients to health facilities when necessary (e.g., for family planning methods that might be unavailable, for the evaluation of side effects)?
- Client satisfaction surveys should also be included in your supervision plan to help identify gaps in service provision, and to help identify strengths and weaknesses from the clients' perspective. Some countries do this quarterly, and it may be a requirement depending on the donor.

### Creative Solutions to Supervision Challenges in Kenya and Benin

In Kenya, supervision of CHWs is typically conducted by the nurse in charge of a local health facility, who makes scheduled supervision visits to the CHWs' homes. However, because of staffing shortages, many health facilities lack a nurse in charge. During Kenya's early scale-up phase, one community had just a single staff member in charge of the health facility, making it nearly impossible to ensure adequate supportive supervision to the CHWs. The coordinating team considered hiring another nurse to step in as a supervisor, but this solution was both too costly and unsustainable. Instead, the overworked supervisor crafted a creative solution in which CHWs came to the facility in pairs and served facility-based clients for a day. This way, the supervisor could monitor the work of the CHWs during his regular work hours and did not have to travel to each of their homes.[31,32]

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Instead of being supervised individually, CHWs in Benin are supervised via monthly group visits to the health center. There are typically seven or fewer CHWs linked to a particular health center, so the group of CHWs to be supervised is manageable. The CHWs meet with the supervisor at the health center (usually a midwife) and the NGO M&E advisor so that data quality can be assessed. This supervision system can be efficient, but it may not be feasible with larger groups of CHWs.


LYDIA JUMBE, CHILD FUND ZAMBIA

## Possible Pitfalls During Component 7

- Failing to recognize the critical role of supervisors in a well-functioning, high-quality CBFP program.
- Not sufficiently supporting supervisors with mandates, time, training, and transport allowances that enable them to evaluate and support CHWs.
- Supervisors not regularly checking CHWs' ability to calculate the reinjection date and determine if a client is within the approved reinjection window.
- Neglecting to supervise how CHWs complete forms.
- Neglecting to ensure that CHWs correctly counsel clients about the availability and potential side effects of various family planning methods (which may lead to discontinuation).
- Developing logistics management, referrals, and waste management procedures that vary greatly from procedures already in place.

# Component 8

## Document and Share Processes and Outcomes

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# Component 8

## Document and Share Processes and Outcomes

Like all family planning programs, programs in which CHWs are providing injectable contraception should be routinely monitored to assess whether the programs are being implemented as planned and to maintain and improve the quality of the services. M&E allows managers to ensure that a program is achieving goals and outcomes, and to identify problems or constraints as well as any unintended consequences. In response to the WHO recommendation that community-based access to injectable contraception be provided with "targeted monitoring and evaluation," FHI 360 has developed *Guidance for Monitoring and Evaluation of Community-Based Access to Injectable Contraception* (https://www.fhi360.org/sites/default/files/media/documents/guidance-injectable-contraceptives.pdf).[33] In addition to the information provided in that guidance document, the following information should be considered in documenting and sharing information related to program performance.

A monitoring, evaluation, and dissemination plan is needed to guide and track the program's progress, its successes, its challenges, and the important lessons learned from these events, and to share this information with stakeholders. The lessons learned provide critical contextual information and important reflections on the implementation process that can be used for program improvement and to inform future scale-up efforts.

### Start early and invest.

- Begin efforts to align program M&E with national HMIS early on, as this can be a lengthy process.
- Ensure that M&E is built into your program from the beginning. Allocate time, money, and staff for M&E. Measure Evaluation recommends that approximately 5 to 10 percent of a project budget should go to M&E.[34]

**Benefits of Carefully Considered Indicators**

For CBA2I, carefully-considered indicators can help managers ensure that adequate numbers of properly trained CHWs have what they need to consistently provide high-quality services and use their skills regularly. The indicators can also help managers ensure that the CHWs are trained to collect accurate, timely, and reliable data.

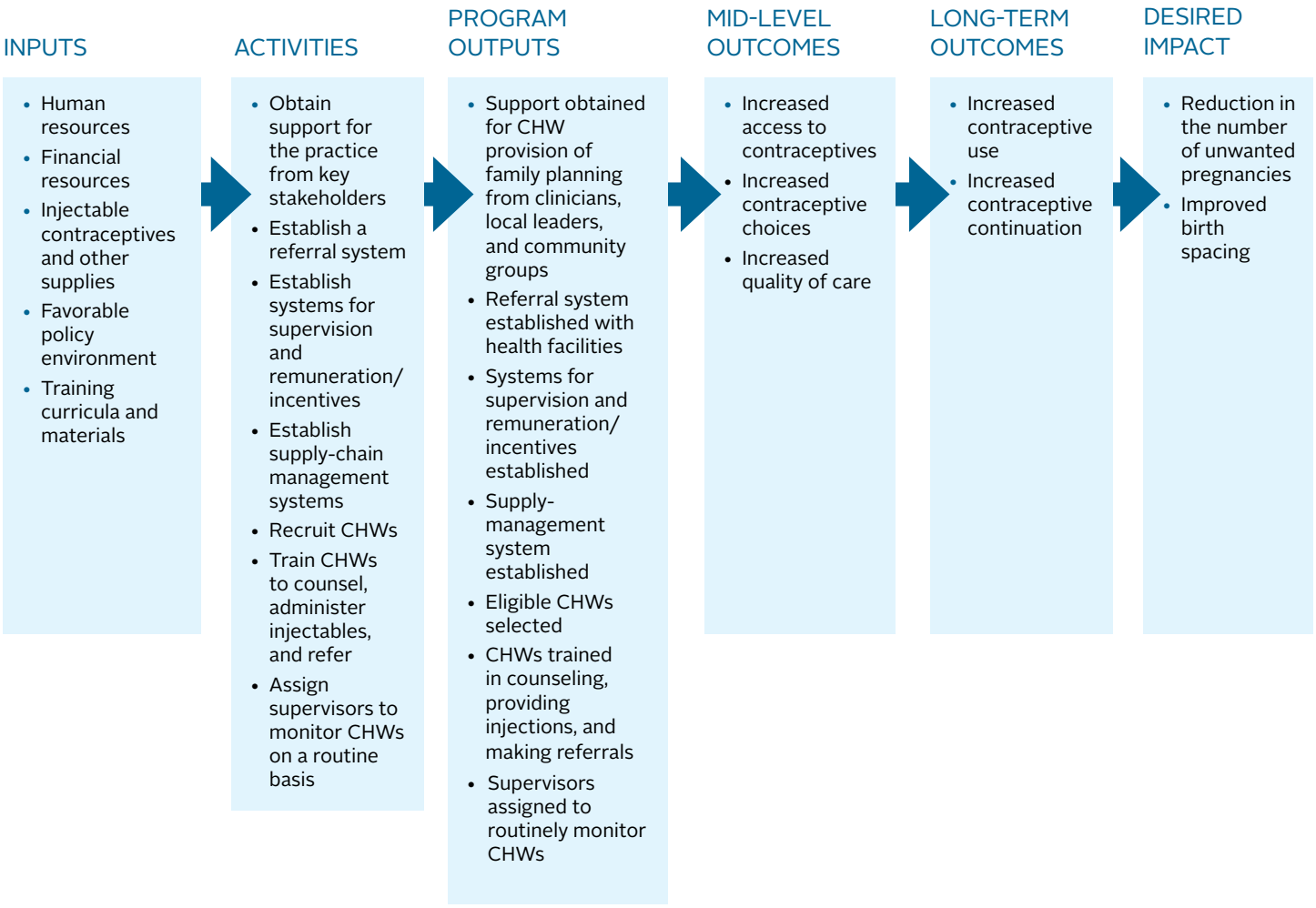
## Involve program stakeholders in all M&E activities from the start.

- The stakeholders involved in M&E should include implementers such as supervisors and CHWs, donors, and the MOH or government. Involve them to ensure a common understanding of the program, to maximize participation, and to foster a sense of ownership.

## Develop a logic model.

- A logic model is sometimes called a conceptual framework or M&E framework. It provides a common language and point of reference for all who have a stake in the program's success. The logic model shows how you will get to your outcomes, based on your inputs, activities, and outputs. In this case, it will show how CHW provision of injectables will reduce unwanted pregnancies and improve birth spacing.
- Use a logic model to articulate how you will reach the program's goals and objectives. Start with your desired impact and work backwards. Once you have determined your desired impact and outcomes, ask yourself what activities do you need to perform to reach those outcomes? What inputs do you need to perform those activities?

## A Sample Logic Model for CHW Provision of Injectable Contraception



## Select indicators to determine what will be measured.

A good indicator will be based on data that are reasonably feasible to collect and have a clear definition. As a rule, indicators should follow the SMART criteria—specific, measurable, achievable, realistic, and time-bound. An example of a SMART indicator is "at least 80 percent of CHWs trained in providing injectables will have passed a post-training test with a score of 85 percent or higher by the end of the fiscal year." These indicators will help you gauge, in meaningful units, the amount of change that occurs. They will eventually help you determine whether program-level goals have been met. Think carefully about the information that needs to be collected to adequately measure progress. Each indicator you include must be essential for managing and improving the new service. For a list of recommended indicators, refer to page 2 of Guidance for Monitoring and Evaluation of Community-Based Access to Injectable Contraception (https://www.fhi360.org/sites/default/files/media/documents/guidance-injectable-contraceptives.pdf).

- Standard forms, indicators, and processes from the national HMIS should be used whenever possible to accommodate the needs of established data collection systems, although additional information may be required for demonstration or scale-up projects. If the HMIS does not allow for disaggregation by cadre of worker providing the injection, explore whether it is possible to add that information. Knowing the impact of CHWs, separate from the impact of facility-based workers, is important for project monitoring and for raising the visibility of CHW provision of injectables as an important strategy to help countries achieve their long-term family planning goals.
- Process indicators track whether a demonstration and scale-up project was implemented as intended and help identify ways to improve the program. For more detailed definitions of indicators, see Appendix 6. Examples of process indicators include:
  - Number/percent of CHWs certified to inject contraception
  - Number/percent 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 the practicum
  - Number/percent of villages/catchment areas with a CHW certified to provide injectable contraception
  - Number/percent of CHWs reporting a stock out of injectables
  - Number of injections provided
  - Number/percent of CHWs submitting data reports on time
- Outcome indicators measure whether a program achieved its established goals and whether the intervention was successful. Examples of outcome indicators include:
  - Number of new family planning users who accepted an injectable from CHWs over a predetermined period
  - Proportion of eligible CHW DMPA clients who received at least one reinjection from the CHW over a predetermined period

- Proportion of change in CYP for a type of injectable (although for this indicator, the baseline CYP will be needed to compare CYP for injectables before and after CHW service provision in the intervention location)

## Create a plan for data collection.

A plan for data collection can be written in a table format so that information can be clearly followed by all involved.

- Make sure the plan contains information such as program activities, indicators, data sources, data-gathering methods, frequency of data collection, expected completion date, and person responsible.
- Identify data sources. Data sources may include monthly service statistics, supply inventory logs, CHW notes, supervision checklists, input from community leaders on their perceptions of the program, and client testimonials and surveys.
- Establish a flow chart and time line for data collection. A table showing your data collection plan—complete with indicators, a time line, and people responsible for each activity—is a good way to organize M&E activities.

### SAMPLE DATA COLLECTION PLAN

| Program Activity | Indicator | Target | Data Source | Frequency of Data Collection | Expected Completion Date | Person Responsible |
|---|---|---|---|---|---|---|
| Train CHWs to provide injectable contraception | # of CHWs trained and certified to provide injectable contraception | 75 CHWs certified after training | Training records | Quarterly | End of Q2 of project year 2 | Training manager |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## Design, distribute, and train on data-collection tools.

- Data-collection forms used by CHWs should be simple to understand and easy to carry. The necessary data points should be included on records maintained by the CHWs. Be sure to field-test all forms with CHWs and others and try to minimize the information-gathering burden you place on the CHWs.

**CHWs need to collect the following information:**

- Names and addresses of clients, or client identification numbers
- Client information (e.g., name, age, address, profession, number of children, number of desired children, telephone number, whether the client has used family planning and, if so, which method)
- Dates of first visit and follow-up visits
- Injectables by type available (e.g, NET-EN, DMPA-IM, DMPA-SC, self-injection):
  - New acceptor
  - Continuing acceptor
  - Dates of injections
- Dates of referrals made and nature of referrals
- Clients lost during follow-up and the reasons (e.g., discontinued family planning, switched methods, got the method from a health facility)
- Unused stock at the end of the month
- Any reportable incidents such as accidental needle sticks or infections or abscesses at the site of the injection

**Supervisors need to collect information on:**

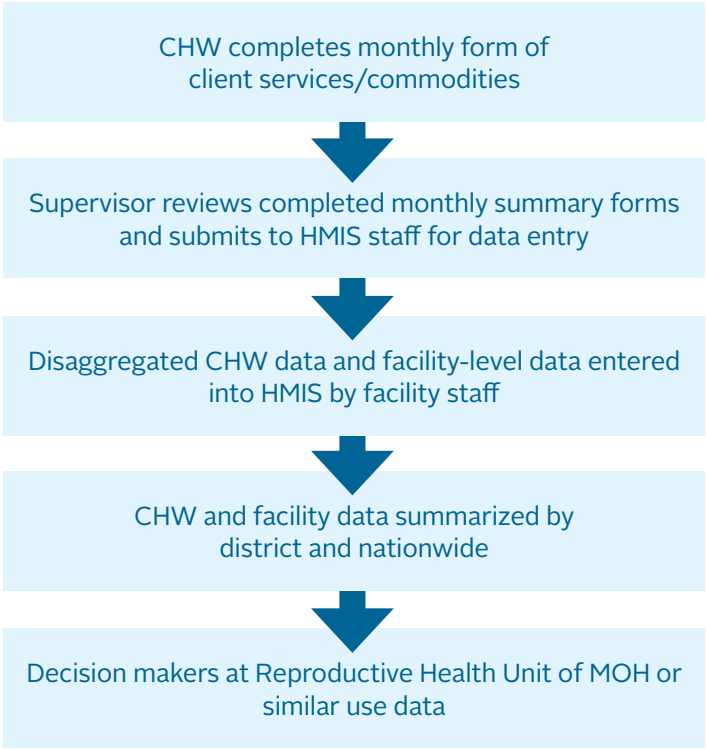
- Names of CHWs
- Community area assigned
- Number of clients and number of visits per client
- Number of injections provided
- Unused stock at the end of the month (should be reported on by both the CHW and the supervisor)



- Train CHWs and supervisors to record information. Emphasize the importance of capturing accurate statistics on their work. For example, stress that complete information can help ensure future funding and that accurate stock keeping will avoid stock outs.

- Enter data and synthesize findings to create activity reports, quarterly reports, annual project reports, briefs, presentations, and talking points.
- Incoming data need to be entered into a database and cleaned to ensure that they are accurate. After the data are entered and cleaned, they should be analyzed on at least a quarterly basis. This analysis should be conducted by someone within the M&E team.
- Determine which key people on the M&E team will lead meetings to discuss the data with those responsible for oversight of the CBFP program. During these meetings, the results should be discussed with program implementers so they will understand the results and so those responsible for analysis and report writing can have the appropriate context surrounding the findings.
- Determine who will lead the report writing to summarize the processes and outcomes of the new service delivery, as well as any programmatic adjustments that will take place as a result of the findings.
- Consider including information on contraceptives and related supplies, as well as statistics from the community health facility, to determine the number of people who use the different family planning methods. In addition, reports on trips, trainings, and finances may be included.
- Review, analyze, and discuss the programmatic implications of the findings with the core resource team. Reporting is not simply a matter of summarizing numbers. It is also an iterative process that requires strategic thinking about the implications of the findings.

## Illustrative Data Flow



## Share findings, exchange knowledge and experiences, and support application.

Utilization of program findings is a gradual process of information sharing in which the project team influences decision makers through a continual stream of information and action planning rather than through a single set of findings. Dissemination activities should be carefully considered and outlined in a dissemination plan focused on the needs of the audience who will use the knowledge.

- Identify dissemination goals, target audiences (i.e., people who will use the results), dissemination activities, and the products to be disseminated, such as data collection summaries and fact sheets.[35] Be sure to share program findings with the local clinic and CBA2I program staff. Those closest to the work often have the best ideas about how to improve it. Seeing the impact of their work can also serve as an incentive for CHWs and health facility staff.
- Interim reporting is critical for keeping stakeholders informed, developing rapport, and building consensus. Dissemination of interim reports and updates should not be treated as optional.
- Submit relevant data to the health facilities for inclusion in the HMIS, and do so according to schedule and using the approved formats. Small changes, such as allowing a disaggregation by the cadre of worker providing the injection, should also be considered.
- Program information should also be shared with a broader regional or international target audience, as many other stakeholders, including MOHs, donors, and international NGOs, are interested in these developments.

### Checklist for Successful M&E

Ensure you have the following documents before beginning to monitor and evaluate CHW provision of injectables:

- ☐ Logic model
- ☐ Indicators and definitions
- ☐ Dissemination strategy
- ☐ Data collection plan, including data collection tools

## Possible Pitfalls During Component 8

- Neglecting to plan and budget for M&E early in the project.
- Not ensuring that relevant indicators are aligned with the national HMIS and that community-level data are being captured.
- Neglecting to develop predetermined, quantifiable indicators to measure program outputs.
- Failing to adequately train CHWs and supervisors on proper record keeping.
- Not creating a dissemination plan for sharing findings and lessons learned that is appropriate for various audiences and includes both national and local stakeholders.
- Disregarding the needs and interests of different stakeholders and disseminating information without changing the format to suit the audience.

# Component 9

## Ensure Successful Scale-Up

# Component 9

## Ensure Successful Scale-Up

After successful introduction, scale-up is more likely to succeed when it has been part of the project's goals and activities from the beginning and when stakeholders have been consistently engaged and involved, as outlined in the preceding components.

### Identify and collaborate with implementing partners, including the MOH.

- Engage partners who may be interested in taking up the practice so that wider scale-up can be achieved with diversified funds. Often, a group of partners will embark on scale-up together.
- There may be several collaborating partners, or you may embark on scale-up with just the MOH. Regardless of the type and number of partners, consider the following questions:
  - Who among the partners will oversee the scale-up process? Consider asking an existing group (e.g., a family planning technical working group) or assembling a new team to serve as an advisory committee for the scale-up process. Clearly define the role of the committee and establish terms of reference to be agreed upon by members.
  - Which partners will be the technical experts in the scale-up effort? Consider working with partners from the original demonstration project who now have implementation experience and technical expertise.

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### Develop a systematic scale-up plan in collaboration with key stakeholders.

A scale-up plan that can be systematically and strategically implemented on a large scale can help ensure that the program achieves the intended impact.[36]

- Engage stakeholders at all levels in the development of the plan, from the MOH to local leaders.
- Focus on the districts or catchment areas with the greatest need, the most support, and the necessary infrastructure.
- Prepare to adapt your model over time, while not losing the essential characteristics that are critical for successful implementation at scale.

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- A scale-up plan should address these critical components:
  - Time line and scope of scale-up
  - Costs, financing, and resource mobilization
  - Advocacy and information dissemination
  - M&E plan with indicators
  - Role of the MOH
  - Roles of various partners
  - Supervision
  - Training
  - Logistics management
  - Selection criteria for CHWs
  - Criteria for allowing women to self-inject

## Identify new champions and build relationships with existing champions for scale-up.

Stakeholder buy-in is essential for the success of scale-up. Without the support of key champions at all levels, scale-up may be hindered or impossible.

- If no stakeholder buy-in exists, form a committed core team with the mandate and time to plan for and support scale-up and sustained implementation. A core team may include researchers, technical experts, champions, program managers, trainers, health professionals, policy makers, and champions.[35]
- If a core team already exists (refer to Component 3 for more information on core teams), re-assess the team to see whether relevant stakeholders are well represented and whether the team's membership needs to be expanded. If any needed stakeholder groups are not currently represented, educate and enlist them as soon as possible.
- Ensure that key stakeholders are either involved in or endorse the scale-up plan.
- Engage in continued, widespread dissemination of results through formal and informal interactions, working groups, study tours, and national meetings to build both champions and the momentum needed to continue scale-up.
- Champions from the demonstration project should advocate for scale-up with new stakeholders, donors, and potential implementers.

## Secure financial resources for scale-up activities.

As explained in Component 2, collecting cost data during the introduction phase will help when estimating the cost of scale-up.

- Engage the MOH, donors, and other resource providers early and keep them informed of program developments so that they can provide up-to-date information when speaking with other stakeholders.
- Be aware of donors' and governments' funding cycles and work within them if you will need additional funding. For example, you can advocate for missions

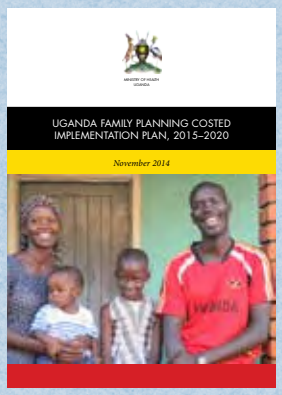
or donors to include CHW provision of injectables in their proposals, requests for assistance, or work orders, and you can advocate for including CBFP into CIPs when possible.

- Advocate with the MOH to include CBFP in the family planning budget line item. This is important for sustainability, for ownership, and to add credibility to the new service.

## CBA2I In National Costed Implementation Plans: Senegal and Uganda

Senegal's 2012–2015 CIP (i.e., plan d'action national de planification familiale 2012–2015) included a plan to complete a pilot project and expand CBA2I to the full 500 functional health huts in the country. The plan included training and supervision of different types of CHWs, and specific costs for these activities.[37]

Uganda's 2015–2020 family planning CIP is a multi-year action plan that outlines the strategies and resources needed for achieving and monitoring the country's family planning goals.[38] Districts have been supported to create district-level CIP action plans to specify how they will respond to national CIP priorities. A best-practices handbook of the district processes will be an output for use by other service delivery partners in a subnational rollout of the CIP.




## Policy Support for CHW Provision of Injectable Contraception is Ideal, But Not a Prerequisite, for Scale-Up

- Each country's process for policy change is unique, but strategic advocacy is almost always necessary for policy change and sustained support.
- Because policy change can take up to several years, it may be possible to secure alternatives, such as policy addendums, to implement and scale up CHW provision of injectables so that service delivery can continue while policy change is being pursued.
  - The expansion of CHW provision of injectables in Madagascar and Zambia offers contrasting examples of policy change and scale-up.
  - In 2006, Madagascar became the first country in sub-Saharan Africa to formally amend its policy to allow CHWs to provide injectable contraception. The policy was enacted with the understanding that pilot testing would be conducted to ensure the safety, feasibility, and effectiveness of this approach within Madagascar.[32]
  - In Zambia, the process to formally change policy is still underway— more than seven years after the conclusion of the pilot study. However, Zambia has managed to begin national scale-up through authorization from the MOH in the form of an authorization letter (known locally as a "waiver") issued in 2016. Since 2016, the Zambia MOH has issued additional authorizations to allow CHWs to administer DMPA-SC.

- Consider costs that may have not applied during the introduction phase. Such costs may include financial or in-kind compensation for CHWs, additional costs for policy or guideline development, or additional commodities needed because of the expanded availability of family planning.

### M&E is necessary for successful scale-up.

- The M&E plan for scale-up can be based on the demonstration project's M&E plan but should be re-examined and amended to ensure that it is aligned with scale-up goals. Changes also can be made if stakeholders want to obtain any new data not collected during the demonstration project.
- The outcomes of scale-up activities should be measured in order to demonstrate effectiveness or make midcourse changes.

## Possible Pitfalls During Component 9

- Assuming scale-up requires formal policy change.
- Assuming that self-injection cannot be introduced and scaled up alongside DMPA-SC. Given the strong evidence base on DMPA-SC and self-injection, new research is not generally needed.
- Engaging critical stakeholders only at the end of the program, rather than throughout.
- Not designating a group of individuals (i.e., a core team) responsible for guiding scale-up.
- Not clarifying the roles and responsibilities of partners involved in scale-up, including the MOH, donors, district health officials, facility staff, and implementing organizations.
- Assuming there is a need to extend the CHW provision of injectable contraceptives to all parts of the country. Regions with an extensive network of health facilities may not have the same need for community-based service delivery as other areas.

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# Appendices

# Appendix 1

## Rapid Assessment
## Site Identification for CHW Provision of Injectable Contraception

This assessment tool may be adapted and used to determine whether a particular CBFP program is suited for the addition of injectable contraceptives to the existing method mix. Sections include information about the geographic location, local health system, CBFP program details, and supervision resources.

NAME/POSITION OF RESPONDENT: _____

DISTRICT AND CONTACT INFORMATION: _____

ASSESSMENT DATE: _____

**Assessment sites** *(please list):*

_____

_____

### A. About the district

**Sources of information** *(please list):*

_____

_____

1. What is the district contraceptive prevalence rate? _____
2. What is the main challenge in the district with respect to family planning (FP) services?

   _____
3. Are there underserved populations? What special characteristics do these populations have? _____
4. How many health facilities are there in the district? Hospital – level II and above *(by name)* _____
5. How many health workers are trained in FP at each of the health facility levels? *(indicate facility and number trained)* _____
6. What FP services are provided at level II? _____
7. What is the FP commodity status of the district? Is stockout common? _____

   _____
8. What is the most used FP method in the district? _____

   _____

# Appendix 1

9. Does the use of FP services vary by other geographic boundaries in the district, such as divisions or service delivery points? *(indicate exact variations by locations)*_____

_____

_____

## B. Information about CBFP Activities in the District

**Sources of information** *(please list):*

_____

_____

1. In which specific areas of the district is the CBFP program implemented? _____
2. Which specific health facilities have linkages with the CBFP activities? _____

_____

_____

3. How long has the CBFP program been running? _____
4. How is it funded? _____

_____

5. What is the duration of current funding? If funding ends soon, what are the plans for securing new funds?_____

_____

_____

6. What is the total number of CHWs? _____
7. What services do the CHWs provide? Include which methods they provide and any other roles or responsibilities they have in the community._____

_____

_____

8. Is there regular reporting of CBFP activities at the health facilities?_____
9. What is the average number of clients per CHW every month? _____
10. Are there records showing the quantity of commodities supplied by the health facility to CHWs? _____
11. Are there referral records for the CHWs? What is the most common reason for referral?

_____

12. How are CHWs selected? What are the criteria?_____

_____

_____

13. How are CHWs trained? Are trainings on a routine schedule? If so, when? When was the last training conducted? _____

14. How are CHWs supervised? _____

15. How is follow-up of clients monitored? _____

16. Are CHWs linked to the government health facilities? What is the nature of the link? _____

17. Are there any incentives for the CHWs? *(please specify)* _____

18. Who are the point people for CBFP activities within the district? _____

19. Please provide your opinion about the current and past operation of the CBFP program.

20. Which areas of the CBFP program need improvement? _____

21. Assuming CHW provision of injectable contraception was to be implemented in your district, how would you ensure the following? *(your response should assume district responsibilities, with no financial support from an NGO)* _____

    a. Adequate stocks _____

    b. Quality control (hygiene, safety) _____

    c. Adequate supervision _____

    d. Referral _____

    e. Integration into the district health system _____

# Appendix 1

22. If not already present at today's meeting, who would be the district-level point person for coordination of a pilot project? Are there other key stakeholders who should be involved?

_____

_____

23. Is there someone you consider to be a champion or leader—such as a district official, supervising nurse or physician, or CHW — within the CBFP program?_____

_____

_____

## C. Information about DMPA Provision at Health Facilities Linked to CBFP

**Source of information** *(facility supervisor):*

_____

_____

1. What is the average monthly number of clients who receive all family planning methods (e.g., combined oral contraceptives, injectables, implants, and IUDs) from this facility?

_____

2. What is the average monthly number of clients who receive injectable contraception at this facility? _____
3. What is the average monthly number of patients who are attended to at this facility?

_____

4. How many trained health workers provide injectable contraception at this facility?

_____

5. Do you think there are an adequate number of trained health workers who can provide injectable contraception to clients at this facility?

_____

_____

# Appendix 2

## Recommendations and Sample Plan for Training CHWs to Provide Injectable Contraception

This guidance was compiled from projects in several countries. Lessons learned from these country experiences include recommendations for:

- illustrative competencies/foundational skills for CHWs providing FP/RH services,
- learning objectives for training experienced CHWs, who are already providing other FP methods and services, to also offer DMPA intermuscular (IM) or subcutaneous (SC) injectables,
- a plan/schedule for conducting the CHW training and supervisor orientation for CHW provision of DMPA IM/SC injectables,* and
- logistical guidance for organizing the practicum.

*This sample plan/schedule allots time for conducting training activities that address the learning objectives specific to provision of DMPA IM/SC injectables by experienced CHWs. This example presumes that participants have the prerequisite foundational skills outlined in the list of illustrative competencies. If participants do not have the prerequisite skills, the scope of the learning intervention would need to be expanded to include objectives and activities that address those knowledge/skills gaps. The foundational skills described in the competencies should be developed prior to, or in concert with, method-specific skills related to the provision of DMPA IM/SC injectables.

### Illustrative Competencies for CHWs to Provide FP/RH Services

Prior to the training, CHW should be able to:

1. Describe the purpose of the community-based FP/RH program and how it fits into the structure of the health system.
2. Describe the role of CHWs and what support they can expect from their supervisors and other providers.
3. Explain the health and other benefits of FP for infants, mothers, fathers, families and communities.
4. Describe the menstrual cycle as relates to pregnancy prevention and family planning.
5. Describe the factors that affect contraceptive method choice (e.g., fertility intentions, cost, previous method experience, resupply access, dual protection).
6. Use effective communication and counseling skills during CHW-client interactions (e.g., positive non-verbal behavior, active listening, effective use of questions, maintaining rapport).
7. Explain the characteristics of available methods in a manner that allows a client to make an informed choice (may use a counseling tool).
8. Demonstrate use of the pregnancy checklist and screening checklists for method eligibility (i.e., oral contraceptives (OCs).
9. Describe/demonstrate in a manner understood by clients how to use FP methods provided by CHWs (male and female condoms, Standard Days Method/CycleBeads, OCs, injectables, ECPs).

# Appendix 2

10. Demonstrate how to conduct an initial client visit and follow-up visit.
11. Refer for methods not offered by CHWs, for treatment of side effects, or other conditions (e.g., STIs).
12. Explain logistical procedures (storage, disposal, re-supply).
13. Demonstrate proper use of forms for recordkeeping and reporting.
14. In some programs CHWs may also be asked to:
    - Describe how to develop and implement a community mobilization strategy.
    - Demonstrate how to conduct discussions, demonstrations, role plays and other facilitation skills required to lead group talks.

**Duration of the DMPA IM or SC injectables training:** As shown in sample plan (see page 84)—allow about 3 to 4 days in a classroom setting for supervisor orientation and training the CHWs (duration varies with the need for administrative sessions and for the review of other FP/RH competencies). The final day of classroom training includes joint sessions with CHWs and their supervisors.

Allow about 1 to 2 weeks in a health facility for a minimum number of supervised injections as specified in the MOH service delivery guidelines; in most countries this is 5 injections (the practicum duration will vary depending on the availability of clients seeking injectables in the clinic sites where the practicum is being conducted).

If the CHWs are already trained in counseling and provision of one type of injectable (e.g., DMPA-IM), it may be possible to reduce the number of supervised injections required for the new type of injectable (e.g., DMPA-SC).

**Number of participants:** About 15 to 20 experienced CHWs and relevant CBA2I program staff or health facility supervisors.

**Number of trainers:** About 2 to 3 trainers, ideally local MOH master trainers from the region and/or district.

**Certification:** Successful completion of the training program and completion of the practicum requirements, performed to standard as determined by the practicum supervisor using the Checklist for Evaluating CHW Counseling and IM/SC Injectables Method Provision (Appendix 5).

## Learning Objectives for Training CHWs to Provide DMPA IM or SC Injectables*

By the end of the training and practicum, participants will be able to:

- Explain the goals and basic structure of the community-based access to DMPA IM/SC injectables program
- Provide informed choice counseling and accurate information about how to use injectable contraceptives
- Use the medical eligibility checklist for injectable contraceptives to correctly screen the required number of clients

# Appendix 2

- Provide injectable contraception per established quality standards for the required number of clients
- Demonstrate how to screen clients for reinjection using the reinjection job aid
- Provide information on DMPA IM/SC injection safety and demonstrate infection-control techniques
- Maintain accurate records on clients and contraceptive commodities and services

* The plan can be used/adapted for either DMPA IM or SC injectables. If the CHWs are already providing IM injectables and are learning to provide SC injections, the amount of time allocated to training on counseling about side effects, screening for eligibility, conducting reinjection visits, and recordkeeping can be reduced.

# Appendix 2

## Plan for training experienced CHWs to provide DMPA injectable contraception (IM or SC)

| Time | Supervisor Orientation<br>**DAY 1** (~7.25 hours) | CHW Training<br>**DAY 2** (~6.75 hours) | CHW Training<br>**DAY 3** (~6.75 hours) | Joint Sessions<br>**DAY 4** (~7 hours) | CHW Practicum<br>(1-2 weeks at clinic) |
|---|---|---|---|---|---|
| **8:30-9:00** | **Welcome/ Introductions**<br>30 minutes | **Welcome/ Introductions**<br>30 minutes | **Agenda/Review/ Warm-Up**<br>30 minutes | **Agenda/Review/ Warm-Up**<br>30 minutes | **Supervised Practicum at Health Facility**<br>Observation and constructive feedback provided with clients who select injectables and receive an injection. Typically, a minimum of five injections.<br>CHW is certified if the practicum supervisor determines that the CHW is performing to standard.<br><br>*Determine whether commodities for the practicum will come from CHW kits or the facility's supply. If the health facilities will supply the commodities, distribute commodities after the CHW has been certified. |
| **Early morning session** | **Overview of Objectives**<br>30 minutes<br>**Goals/Structure of CBA2I Program**<br>30 minutes | **A. Overview of Objectives and CBA2I Program**<br>30 minutes<br>**B. Characteristics of IM/SC Injectables** 35 minutes | **H. Giving Practice Injections to Fruit**<br>60 minutes<br>Work in Pairs with Trainer Supervision | **L. Injectables Fun Facts Game**<br>45 minutes<br>Team Activity | |
| **BREAK** 15 minutes | | | | | |
| **Late morning session** | **Expanded Supervisor and CHW Roles/ Responsibilities**<br>30 minutes<br>**Intro to CHW Kit Additions & New Job Aids**<br>45 minutes | **C. Why Women Like/Dislike IM/SC Injectables**<br>15 minutes Brainstorm, Present, Discuss<br>**D. Who Can or Should Not Use Injectables –**<br>60 minutes Presentation/ Checklist practice | **H. Giving Practice Injections (continued)**<br>75 minutes Work in new pairs with supervision from trainer | **M. Recordkeeping**<br>75 minutes<br>Overview, Practice form filling | |
| 12:30 pm — **LUNCH** 60 minutes | | | | | |
| **Early afternoon session** | **Characteristics of Effective Supervisors (Refresher)**<br>60 minutes<br>**Introduction of DMPA Skills Checklist**<br>15 minutes | **E. Injection Demonstration**<br>45 minutes – Demonstrate, Present<br>**F. Needle Safety/Accidental Needle Stick –** 30 minutes<br>Demonstrate, Present, Discuss | **I. Counseling about Injectables**<br>60 minutes Present, Work in pairs<br>**J. Determining the Reinjection Date**<br>30 minutes Present, Group Activity | **N. Role Playing**<br>90 minutes – Practice injectables provision (counseling, screening, safe injection, reporting) with peers while supervisors use skills checklist and provide feedback | |
| **BREAK** 15 minutes | | | | | |
| **Late afternoon session** | **Practice Providing Constructive Feedback using DMPA Skills Checklist**<br>90 minutes | **G. Finding Injection Site on Arm**<br>60 minutes<br>Demo, Practice with Multiple Partners | **K. Conducting Initial and Reinjection Visits**<br>60 minutes – Overview and practice with reinjection job aid | **O. Practicum Orientation**<br>30 minutes – Review, Discuss expectations<br>**P. Distribute Forms, Supplies and Equipment**<br>60 minutes<br>Injectables-related for CHW kits* | |
| **16:30 – 17:00** | **DAILY WRAP-UP**<br>**Assigned Reading**<br>Review updated procedures and recordkeeping forms | **DAILY WRAP-UP**<br>**Assigned Reading –** Review new job aids and how-to-use injectables pages to be included in counseling tool | **DAILY WRAP-UP**<br>**Assigned Reading** – Review new recordkeeping forms | **COURSE WRAP-UP** | |

# Appendix 2

## Logistical Guidance for Organizing the Clinical Practicum

Compiled below is some basic guidance to help organize the logistics for the clinical practicum. The *Training Skills for Health Care Providers, Reference Manual, Third Edition* (Jhpiego, 2010) contains additional guidance for organizing a clinical course including chapters on supervising and conducting assessments in the clinic, protecting client's rights, and dealing with unexpected problems.

- Select larger facilities (e.g., Health Centre IV or hospital) with sufficient client load and choose days when client load is at its peak (e.g., immunization days).
- Mobilize communities (e.g., radio spots) so that clients are aware that there will be additional capacity at the facility to provide FP services on the day(s) of the practicum.
- Meet with the facility in-charges/staff in advance to make arrangements:
  - identify qualified providers who can serve as preceptors and ensure that they understand their roles/responsibilities as relates to oversight of the practicum and the safety/risks to clients
  - determine how many trainees can be accommodated at each site based on a pre-determined ratio of clients/preceptors/trainees
  - orient the preceptors to the practicum requirements; share copies of the Checklist for Evaluating CHW Counseling and IM/SC Injectables Method Provision for use in evaluating/documenting trainee performance
  - provide preceptors guidance about offering performance feedback and when to intervene if a client is at risk of harm
  - ensure commodities and supplies are available to meet the demands created by the practicum
  - request that the in-charge/preceptor be prepared to provide for the trainees on the day of the practicum a brief orientation to the clinic outlay, FP methods available, records, client flow, drugs available and any other relevant information
- Assign each trainee to a preceptor/facility in advance.
- Ensure that trainees understand their responsibilities as related to the practicum: 1) are prepared to perform each skill/objective to the established standard, 2) self-monitor the achievement of their clinical objectives, and 3) bring with them to the practicum site their Job Aids Booklet, Counseling Tool, and uniform or other identification.
- Arrange transport for trainees to/from the practicum sites.
- Arrange for beverages and snacks for tea break at the practicum sites.
- Summarize CHW performance (e.g., passed certification criteria, deficiencies and proposed remedies) and submit with training report.

# Appendix 3

## CHW Counseling Tool for FP and Guidance for Adaptation and Use

### Introduction

The *Community Health Worker Counseling Tool for Family Planning* is a prototype counseling tool suitable for community health workers (CHWs) who offer family planning counseling. The goal of this tool is to enhance the quality of family planning counseling and service provision at the community level. This tool was originally developed between 2010 and 2011 for the *Training Resource Package for Family Planning*. It was further refined during the *Technical Consultation on Community Counseling,* a collaborative effort convened by the World Health Organization (WHO), the Population Council, and the United States Agency for International Development, held in July 2011 in New Delhi, India. The concepts included in this tool were drawn from several existing counseling tools, including the *Guide to Family Planning for Community Health Workers and their Clients* developed by the World Health Organization, 2011, and *The Balanced Counseling Strategy: A Toolkit for Family Planning Service Providers*, published by the Population Council, 2008. In 2017 the tool was updated to reflect the current eligibility criteria for contraceptive use (WHO 2015[1]).

The tool comprises a series of questions adapted from the *Balanced Counseling* methodology, a method choice chart, and information about contraceptive methods organized to guide the CHW through the counseling process and help clients choose and use a family planning method that suits their needs. The tool can also be used with clients who already have a method in mind or who need to be reminded about how to use the method they are currently using. Use of the method choice chart empowers the client to take ownership of the contraceptive decision-making process while at the same time, providing information about method effectiveness.

### Why the Community Health Worker Counseling Tool for Family Planning?

In a 2014 Population Council-led study (Ahmad 2014[2]), the *CHW Counseling Tool for Family Planning* was field-tested in India with CHWs, known as ASHAs, alongside the Population Council's *Balanced Counseling Strategy (BCS)* and the WHO's *Guide to Family Planning for Community Health Workers and their Clients (Field Guide)* for general utility and effectiveness. The study authors found that all three counseling tools improved ASHA's counseling skills and client interactions, and helped women make informed choices when selecting their contraceptive method. Furthermore, the *CHW Counseling Tool for Family Planning* compared favorably to the other tools and offered advantages, in that it is portable, easy-to-use by CHWs and allows privacy between the CHW and the client

[1] Medical eligibility criteria for contraceptive use—5th ed. Geneva: World Health Organization, 2015.

[2] Jaleel Ahmad, Isha Bhatnagar, M.E. Khan and Charlotte Warren. 2014. "Evaluation of the Feasibility, Utility and Effects of the Use of FP Tools at the Community Level in India." New York: Population Council.

# Appendix 3

during the counseling session. The inclusion of this job aid in community-based family planning programs offers the opportunity to increase the quality of CHW counseling at the community level and promotes the principles of voluntarism and informed choice.

## How to Use the CHW Counseling Tool for Family Planning

The tool follows this general counseling/screening process:

- assess the client's needs
- ensure the client is not pregnant
- ask questions to help the client narrow the possible method options*
- present information so the client can choose a suitable method
- if the client selects injectables or COCs, screen the client to determine if she is eligible using the medical eligibility checklists included in the tool, and
- give the client information about how to use the method.

* The method choice chart (last page in the PowerPoint file; request file from CBA2I@fhi360.org) should be used by the client as she answers the set of questions designed to identify methods that suit her needs. The client should use a small piece of paper or other item to cover the methods that do not suit her needs. If a CHW has been trained to offer counseling to couples, the counseling tool could be used to support a couples' counseling session.

### Guide to Printing the CHW Counseling Tool for Family Planning

The counseling tool should be printed in color (the information on the methods is color-coded to facilitate ease of use) and copied front/back in landscape/horizontal format (when viewing, even pages should be on the left, odd pages should be on the right). The pages should be bound using a spiral coil so that the tool/manual will lay flat when opened. The method choice chart (last page in the file) ideally would be printed on heavy paper and laminated—it should not be bound with the rest of the manual. Some CHWs may find it helpful to create and affix tabs to the pages that they use most often.

### Guide to Counseling Clients using the CHW Counseling Tool for Family Planning

1. Sit side-by-side so that the CHW and the client can see each other's face and talk privately.
2. Place the method choice chart directly in front of the client with the counseling tool where both the client and CHW can see it (see illustration).
3. Point to information on the method choice chart and the tool pages to help explain key information.
4. Use the color-coded bars (or add tabs) to find information and move from one section to another.

# Appendix 3

5. Use pages 4–7 to tell the client what you will do during the session, learn more about what the client needs, and explain how the client can benefit from family planning.
6. Use pages 8–9 to make sure the client is not pregnant.
7. If the client knows what method she wants, go to that method and explain how to use it.
8. If the client does not know what method she wants, ask the questions on pages 10–19; and, instruct the client to use the method choice chart to help track and select possible method options.

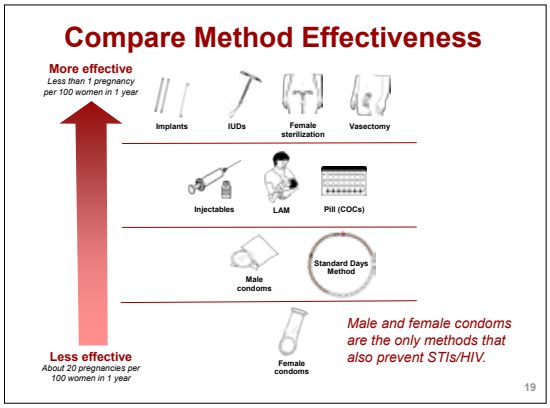
When used properly, the design of the tool supports client-provider interaction by facilitating eye contact, allowing equal access to easy-to-understand information, and enabling confidential discussions.

9. Use the first page of each method to provide an overview of the methods that a client may be interested in using.
10. After the client selects a method, use the second page of each method to describe how to use the method.
11. Use the eligibility checklists on pages 42–43 to make sure a client can safely use pills or injectables.

### Guide for Adapting the Prototype Tool

There is guidance throughout the prototype tool captured in the speaker notes view of the PowerPoint file (request file from CBA2I@fhi360.org) to describe possible adaptations to specific pages. Here are some general recommendations regarding adaptations that should be considered when using the prototype:

1. Whether adapting the prototype tool or developing a new tool, use the Checklist for Evaluating Family Planning Counseling Tools for Community Health Workers (Annex A) as a guide.
2. Ensure the tool matches the mix of methods available to clients—either from CHWs or by referral—by removing or inserting pages and/or specific pieces




METHOD EFFECTIVENESS CHART FROM THE PROTOTYPE TOOL; NOTICE THAT IT HAS BEEN ADAPTED/SIMPLIFIED TO SHOW ONLY THE METHODS MENTIONED IN THE PROTOTYPE.

# Appendix 3

of information about the available methods. For example, the Compare Method Effectiveness chart (included as Annex B) shows all of the methods; however, in the prototype tool the chart has been modified to show only the methods mentioned in the prototype (see image).

3. Place the pages describing the methods in whatever order makes sense. The pages can be in any order because ultimately the client's method choices will determine which pages the CHW uses; and the color coding (and the addition of hand-made tabs) will make the pages easy-to-locate. In the prototype tool, the order places the methods that a typical CHW might counsel about most often, first. However, if the CHWs in your program primarily counsel postpartum women, making LAM the method that CHWs counsel about most often, you may want to reposition the pages about LAM accordingly.
4. As needed, develop and insert culturally-appropriate illustrations and translate the messages to suit the intended audience for the tool. There are additional illustration options included on the pasteboard.
5. Pre-test the tool and the accompanying training/orientation with CHWs to ensure that it works for the CHWs and their clients—adjust the tool and training as needed to achieve the desired results.

**Guide to Training on the CHW Counseling Tool for Family Planning**

The tool should be introduced during a structured training that includes a thorough overview of the characteristics of family planning methods so that CHWs can demonstrate knowledge and confidence when explaining methods during their interactions with clients. The training intervention should also feature role plays and case studies that allow CHWs to practice with the counseling tool in multiple real-life simulations and receive constructive feedback to improve their performance. A supervised practicum with on-the-job mentoring further ensures that CHWs can use the tool as intended and increases the likelihood that their clients can make a free and informed choice.

Included in this guide (Annex C) is a skills checklist that can be used initially to assess CHW progress while they are learning to use the counseling tool and later by supervisors to evaluate on-the-job performance related to counseling and basic method provision. The checklist also includes an additional set of items that can be used when evaluating the skills of CHWs who have received the special training needed to manage couples' counseling sessions.

# Appendix 3

## Annex A—Checklist for Evaluating Family Planning Counseling Tools for Community Health Workers

This checklist is designed to help programs decide whether a counseling tool for use by community health workers meets a standard set of criteria for usability and content. The criteria are designed to ensure that the tools are user-friendly for both CHWs and their clients and technically accurate to support high-quality, informed choice counseling. The prototype tool, *Community Health Worker Counseling Tool for Family Planning*, provides one interpretation of how these criteria can be applied to create an effective counseling tool.

A good counseling tool supports dynamic interaction between CHWs and their clients in a manner that provides:

- Respect for a client's choices
- Efficient decision-making and problem-solving
- Personalized, accurate, and effective information-giving
- Good interpersonal communication
- Tailored counseling that meets a client's needs
- Support for continued method use

Use the criteria below to evaluate any newly designed or adapted counseling tool.

***Usability***

**Yes No**

❑ ❑ The tool is arranged in an order that supports a structured, client-centered decision-making process.

❑ ❑ The instructions/prompts for using the tool are clear.

❑ ❑ The instructions for how to disseminate the tool (e.g., print, electronic) are clear.

❑ ❑ The language (words used) are easy for CHWs/clients to understand.

❑ ❑ The key messages for clients are easy to understand.

❑ ❑ The illustrations in the tool are clear, easy-to-understand, and culturally appropriate.

❑ ❑ Information provided is complete (nothing missing).

❑ ❑ Information provided is correct (technically accurate).

***Content***

**Yes No**

❑ ❑ Information on available family planning methods is provided—including clinic-based methods.

❑ ❑ Information about the general benefits of child spacing and family planning is provided.

❑ ❑ Information on each FP method includes:

- how effective the method is compared with other methods
- how to use the method (including when to start and return)
- benefits and risks
- side effects (including expected bleeding changes)
- who can use (e.g., postpartum, never pregnant)
- common myths and misconceptions

❑ ❑ Eligibility criteria/checklist(s) to ensure compliance with WHO eligibility criteria are provided (as needed).

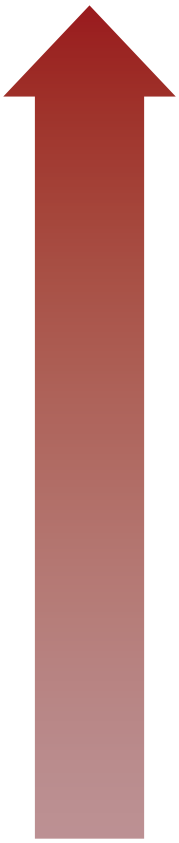
❑ ❑ Information about dual protection to reduce STI/HIV infection is provided.

❑ ❑ Information about when/how to use emergency contraception is provided.

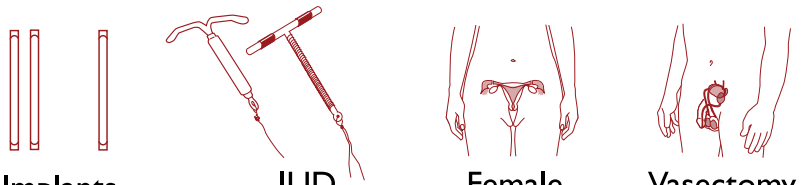
❑ ❑ Guidance for ruling out pregnancy is provided.

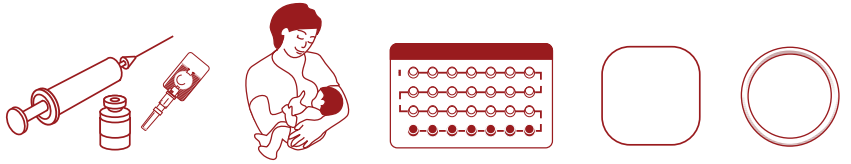
# Compare Method Effectiveness

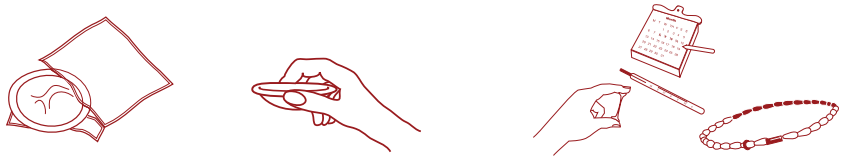
**More effective**
Less than 1 pregnancy per 100 women in one year



**Less effective**
About 20 pregnancies per 100 women in one year




# Appendix 3

## Annex C—Observation Checklist to Assess Family Planning Counseling Skills of CHWs During Simulation or Practicum

**CHW:** _____ **Client:** _____

**Observation #** _____ **Supervisor:** _____ **Date:** _____

**Client's permission to participate in practicum obtained:** _____ **client's initials** _____ **supervisor's initials**

| **Overall: Communicate Effectively and Maintain Rapport** | Yes | No | N/A |
|---|---|---|---|
| Shows respect and avoids judging client | | | |
| Maintains relaxed, friendly and attentive body postures and eye contact | | | |
| Uses simple, clear language | | | |
| Uses open-ended and probing questions correctly | | | |
| Listens carefully to client (paraphrases and reflects) | | | |
| Asks client about feelings (and shows empathy) | | | |
| Describes client's roles/responsibilities for the session | | | |
| Encourages client participation | | | |
| Explains what will occur during visit and procedures | | | |
| Ensures client understanding and corrects misunderstandings | | | |
| Uses job aids appropriately | | | |
| Correctly records information on data-collection forms | | | |
| **Establish Rapport and Assess Client's Needs and Concerns** | | | |
| Greets client appropriately | | | |
| Ensures confidentiality and privacy and that client is comfortable | | | |
| Asks about reason for visit | | | |
| Asks about client's partner(s), children, family, sexual behavior, health | | | |
| Asks about plans to have children, desire for FP (e.g., spacing, limiting) | | | |
| Explores STI risk and what client does to avoid STIs | | | |
| **Provide Information to Address Client's Identified Needs and Concerns** | | | |
| Informs client when needs/concerns are beyond CHW capability | | | |
| Advises on preventing STIs (i.e., abstain, fewer partners, use condoms) | | | |
| Explains benefits of FP and healthy spacing | | | |
| Helps client identify FP methods suited to her or his needs | | | |
| Gives information on FP methods of interest | | | |
| Responds to other client questions or concerns | | | |

| **Help Client Make an Informed Decision or Address a Problem** | Yes | No | N/A |
|---|---|---|---|
| Asks client if he or she has any questions about methods of interest | | | |
| Asks client to choose a method | | | |
| Uses screening checklist to determine if client can use the method | | | |
| Agrees on decision or plan in partnership with client | | | |
| Help Carry Out Client's Decision | | | |
| Gives contraceptive method and condoms for dual-method use, if needed | | | |
| Explains and/or demonstrates correct use | | | |
| Asks client to explain or demonstrate correct use, and reinforces client's understanding and/or corrects client's demonstration | | | |
| Reminds client about side effects and reasons for returning | | | |
| Gives supplies (as needed) | | | |
| Role plays or rehearses negotiation skills and helps client plan approach | | | |
| Arranges follow-up, resupply, and referral to outside services, as needed | | | |
| **Additional Observations Related to Counseling Couples** | | | |
| Creates and maintains a bond/partnership with the couple | | | |
| Shows equal concern for both members of the couple | | | |
| Expresses respect for the couple's relationship. | | | |
| Identifies the couple's shared experiences and history | | | |
| Enables balanced participation of both partners | | | |
| Models appropriate listening and communication skills | | | |
| Supports a dialogue between the couple | | | |
| Considers feelings expressed and observed | | | |
| Raises difficult issues that the couple may need to address | | | |
| Admires and builds on the couple's strengths and self-reliance | | | |
| Empowers the couple to negotiate small behavior changes | | | |
| Eases tension and lessens blame; redirects and rewords questions and discussions that are blaming or unkind | | | |

# Appendix 3

## Annex C—Observation Checklist to Assess FP Counseling Skills *(continued)*

**Observation # _____**

Specific Notes/Observations Regarding CHW Performance

Overall Score for this Interaction

_____ Passed

_____ Failed

CHW signature: _____

Trainer/Supervisor signature: _____

# Appendix 3

## CHW Counseling Tool for FP

Reproduced on the next several pages are miniatures of the pages from the counseling tool. A PDF file of the tool can be obtained from https://www.fhi360.org/resource/community-based-access-injectable-contraceptives-cba2i-select-resources. The original PowerPoint file can be requested from: CBA2I@fhi360.org.


**Purpose**

The *Community Health Worker Counseling Tool for Family Planning* can be used by community health workers (CHWs) to offer family planning counseling.

Use this tool (manual and method choice chart) to help clients choose and use a family planning method that suits their needs.

The tool can be used with clients who already have a method in mind or who need to be reminded about how to use the method they are currently using.

The tool helps you use this general counseling process:

- assess the client's needs,
- ensure the client is not pregnant,
- ask questions to help the client narrow the possible method options,
- present information so the client can choose a suitable method, and
- give the client information about how to use the method.

**Instructions**

- Sit side-by-side so that you and the client can see each other's face and talk privately.
- Place the method choice chart directly in front of the client with the counseling tool where you can both see it.
- Point to information on the method choice chart and the manual pages to help explain key information.
- Use the color-coded bars (and/or add tabs) to find information and move from one section to another.
- Use pages 4–7 to tell the client what you will do during the session, learn more about what the client needs, and explain how the client can benefit from family planning.
- Use pages 8–9 to make sure the client is not pregnant.
- If the client knows what method she wants, go to that method and explain how to use it.
- If client does not know what method she wants, ask the questions on pages 10–19 while using the method choice chart to help her track and select possible options.
- Use the first page of each method to provide an overview of the methods that a client may be interested in using.
- After the client selects a method, use the second page of each method to describe how to use the method.
- Use the checklists on pages 42–43 to make sure a client can safely use pills or injectables.

3

### During this session…

- We will listen to each other.
- Ask questions about anything any time.
- If I do not know the answer, I will find it for you.
- Everything you say is private.
- We will use this manual to guide us as we:
  - talk about your needs and concerns
  - make sure you are not pregnant
  - explore your interest in family planning and which methods might work for you

4

### Tell me about you and your family…

- How many children do you have?
- How old are your children?
- Are you interested in family planning?

**There are many methods of family planning; you can choose one that is right for you.**

***Do you have any questions?***

5

### Keep this in mind as you decide…

Mothers and babies are more healthy if women and girls:

- wait until they are 18 to get pregnant
- wait 2 years after a birth before trying to get pregnant
- wait 6 months after a miscarriage or abortion to get pregnant
- have their children before age 35

*Young women who delay getting pregnant are more likely to finish school.*

6

### Family Planning Benefits Everyone

Benefits to baby:

- Born healthy and strong
- Breastfeeds for a longer period and grows well

Benefits to mother:

- Regains her strength
- More time for baby and to care for the family

Benefits to family:

- More resources for food, clothing, housing, and education

*Young women, women with HIV, and women with disabilities can all benefit.*

7

# Appendix 3

## CHW Counseling Tool for FP *(continued)*

**Before starting a method, let's use these questions to be sure you are not pregnant.**

1. Did your monthly bleeding start in the past 7 days?

2. Have you had no sex since your last monthly bleeding, delivery, abortion, or miscarriage?

3. Have you been using another method consistently and correctly since your last monthly bleeding, delivery, abortion, or miscarriage?

4. Did you give birth in the past 4 weeks?

5. Did you have a baby less than 6 months ago, are you fully breastfeeding, and your monthly bleeding has not returned since then?

6. Have you had a miscarriage or abortion in the past 7 days?

8

**If you answer YES to one question, you are not pregnant. If you answer NO to all the questions we cannot be sure.**

**Unsure if pregnant…**

- Come back when you get your monthly bleeding so we will be sure you are not pregnant.
- In the meantime, use condoms or abstain.
- If you do not get your bleeding when it should come, or you have already missed your monthly bleeding, get a pregnancy test.

**Had unprotected sex (sex without using an FP method) in the last five days and do not desire pregnancy…** Go to pages on ECPs.

**Not pregnant…**

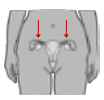
- If you have a method in mind, let's talk about that method now... Go to method page.
- If you do not have a method in mind, I will ask you some questions to help you decide. You can use the method choice chart to keep track of your options… Go to next page. Use the method choice chart.

9

**1. Do you wish to have children in the future?**

10

If YES, remove female sterilization and vasectomy from your choices on the method chart. The CHW explains why.



Female Sterilization

Vasectomy

If NO, these methods are possible choices.

Continue

11

**2. Are you breastfeeding an infant less than six months old?**

12

If YES, remove the Pill (COCs) from your choices on the method chart. The CHW explains why.

Pills

If NO, or if you are not fully breastfeeding, or your monthly bleeding has returned, also remove LAM from your method choices. The CHW explains why.

LAM

Continue

13

## CHW Counseling Tool for FP *(continued)*

**3. Do you have the cooperation of your partner in family planning?**

14

If NO, remove condoms and SDM from your choices on the method chart. The CHW explains why. If desired, help client learn to talk with her partner to add to her method options.


If YES, keep condoms and SDM.

Continue

15

**4. Are there any methods that you do not want to use or have not tolerated in the past?**

The client explains why. What happened?

Remove from the chart any methods you do not want to use.

16

### Respond to Concerns about Methods

- If used correctly, male condoms do not break or come off in the woman's body.
- Pills, implants, and injectables:
  - Do not cause infertility; you can have babies after stopping.
  - Do not cause deformed babies if accidentally given to pregnant woman.
  - Do not cause abortion.
  - Can cause changes to monthly bleeding:
    - changes are normal and not harmful and differ by method.
    - regular pattern returns when method use stops; takes longer for some methods.
    - no menses while on these methods does not mean a woman is pregnant.
- IUDs do not move to other parts of the body.
- It does not cause discomfort during sex.
- It can be removed any time.
- The womb is not removed during female sterilization.
- It does not cause any illness.
- Testicles are not removed during vasectomy.
- It does not cause illness or weakness.
- It does not decrease sex drive, erection, ejaculation, or sexual performance.

**Contraceptive methods do not cause cancer.**
***All methods are safe.***

Continue

17

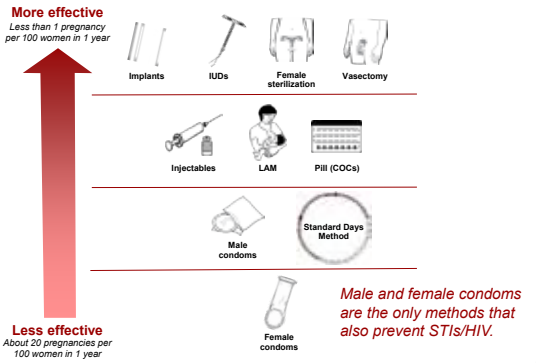
### Here are some things to think about as you compare methods.

- Are there side effects? What would it be like for me if I have them?
- Is it easy to use? Can I use it without others knowing?
- How soon can I get pregnant after I stop?
- Can I get it now? If not now, is there a method I can use in the meantime?
- How long will it last?
- Does it prevent STIs and HIV? If I'm at risk for STIs, what are my options?
- How effective is the method?
- How much will it cost?

*Let's learn about the methods you are interested in...*

18

### Compare Method Effectiveness




*Male and female condoms are the only methods that also prevent STIs/HIV.*

19

# Appendix 3

## CHW Counseling Tool for FP *(continued)*

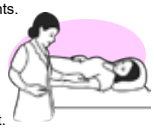
### Implants

- Small plastic capsules or rods placed under the skin of the inside upper arm (1 or 2 capsules or rods depending on type)
- Last 3 to 5 years
- Use with condoms to prevent sexually transmitted infections

20

**Who Can Use**

- Most women can safely use implants.
- Women with certain conditions should not use implants. Refer interested clients to a clinician.



**How It Works**

- Prevent eggs from leaving the ovaries and thickens cervical mucus.
- Can be removed any time if you want to get pregnant.

**What to Expect**

- Start any day of the menstrual cycle, if not pregnant.
- Insertion and removal is quick, easy, and painless.
- Provider bandages the opening – no stitches.
- Bleeding pattern changes are common and may include irregular spotting or no bleeding.
- Return to clinic any time you have questions, problems, or want the implant removed or replaced.

21

### Injectables

(DMPA IM)

- Given by injection every 13 weeks
- Prevents eggs from leaving the ovaries
- May take more time to become pregnant after stopping
- Use with condoms to prevent sexually transmitted infections

22

**Who Can Use**

- Most women can safely use injectables.
- Women with certain conditions should not use injectables. Use the screening checklist to find out, page 42.

**How to Use**

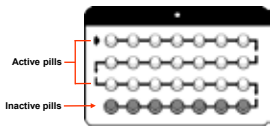
- Get injection every 13 weeks.
- Do not massage injection site.
- Go to the clinic if you have a severe headache with vision problems, yellow skin or eyes, unusually heavy or long bleeding.
- Return on time for injection. Can be 2 weeks early or 4 weeks late. Come back even if late or if you have questions or concerns.

**Some women have:**

- Bleeding pattern changes such as prolonged or heavy bleeding, irregular bleeding or spotting, or no bleeding at all.
- Headaches and dizziness.
- Abdominal bloating and discomfort.
- Changes in mood and sex drive.
- Weight gain.

23

### The Pill




- A pill taken every day to prevent pregnancy
- Prevents eggs from leaving the ovaries
- After you stop taking it, you can have babies
- Use with condoms to prevent sexually transmitted infections

24

**Who Can Use**

- Most women can safely use pills.
- Women with certain conditions should not use pills. Use the screening checklist to find out, page 43.

**How to Use**

- Take one pill at the same time each day.
- If you miss 1 or 2 active pills in a row or start a pack 1 or 2 days late, take a pill as soon as you remember. If you miss any inactive pills throw them away.
- If you miss 3 or more active pills in a row, or start a pack 3 or more days late:
  - Take a pill as soon as possible, continue taking 1 pill each day, and use condoms or avoid sex for the next 7 days.
  - If you miss these pills in week 3, ALSO skip the inactive pills and start a new pack.
- Go to the clinic if you have sharp pain in your leg or abdomen, severe chest pain, or a severe headache with vision problems.
- Return if questions or concerns and for resupply of pills.

**Some women have:**

- Nausea: take the pill with food.
- Headaches and dizziness: take the pill at night and take NSAIDs.
- Irregular spotting: take the pill at same time every day and take NSAIDs.
- Breast tenderness or mood changes.

25

# Appendix 3

## CHW Counseling Tool for FP *(continued)*

### Male Condom

- A thin rubber cover that fits over the erect penis
- Prevents pregnancy and sexually transmitted infections including HIV/AIDS
- Effective when used correctly every time you have sex
- Use alone or with another method
- Can be used by any couple who agrees to use it

26

**Who Can Use**
- Women who have the support of their partners.
- All men can safely use condoms (avoid condoms made of latex if allergic).

**How to Use**

1. Use a new condom for each sex act. Make sure it is not expired.
2. Before any contact, place the condom on the tip of the erect penis with the rolled side out.
3. Unroll the condom all the way to the base of the penis.
4. After ejaculation, hold the rim of the condom in place and withdraw the penis while it is still hard.
5. Throw the used condom away safely.

**What to Remember**
- Use water-based lubricants only.
- Store in a cool dry place.
- Side effects are rare.
- Be careful not to tear when opening or putting on.
- Emergency contraceptive pills can be used if condom fails.

27

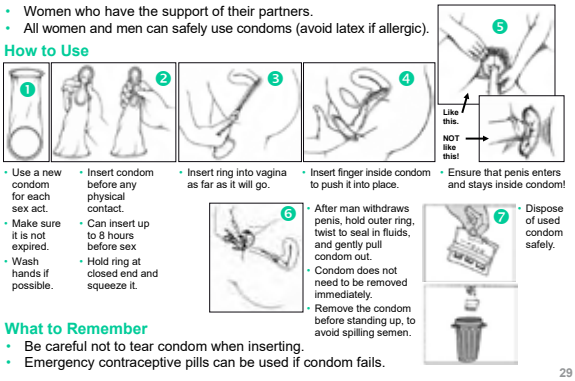
### Female Condom

- A thin rubber lining that fits loosely inside a woman's vagina
- Prevents pregnancy and sexually transmitted infections including HIV/AIDS
- Effective when used correctly every time you have sex
- Use alone or with another method
- Can be used by any couple who agrees to use it

28

**Who Can Use**
- Women who have the support of their partners.
- All women and men can safely use condoms (avoid latex if allergic).

**How to Use**




1. Use a new condom for each sex act.
   - Make sure it is not expired.
   - Wash hands if possible.
2. Insert condom before any physical contact.
   - Can insert up to 8 hours before sex
   - Hold ring at closed end and squeeze it.
3. Insert ring into vagina as far as it will go.
4. Insert finger inside condom to push it into place.
5. Ensure that penis enters and stays inside condom!
6. After man withdraws penis, hold outer ring, twist to seal in fluids, and gently pull condom out.
   - Condom does not need to be removed immediately.
   - Remove the condom before standing up, to avoid spilling semen.
7. Dispose of used condom safely.

**What to Remember**
- Be careful not to tear condom when inserting.
- Emergency contraceptive pills can be used if condom fails.

29

### Lactational Amenorrhea Method (LAM)
(for breastfeeding mothers)

- Breastfeed only, day and night, to prevent pregnancy
- Very effective for 6 months if breastfeeding exclusively and monthly bleeding has not returned
- Do not use bottles, pacifiers or other artificial nipples; these discourage your baby from breastfeeding as frequently
- Use with condoms to prevent sexually transmitted infections

30

**Who Can Use**
- You can use LAM if you meet all three criteria at the same time.

**How to Use**

| 1 | 2 | 3 |
|---|---|---|
| No monthly bleeding since baby was born. | You only breastfeed your baby, day and night. No other food or liquids are given. | Baby is less than 6 months old. |

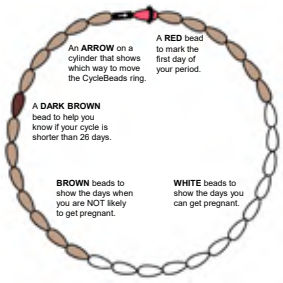
- Must breastfeed often, day and night, even when baby is sick.
- Give no other food or liquids. Medicines and vitamins are okay.
- Have another method ready to start at 6 months, or before, if monthly bleeding returns or breastfeeding decreases.

31

# Appendix 3

## CHW Counseling Tool for FP *(continued)*

### Standard Days Method (CycleBeads)




- Natural method with no side-effects
- Helps you know what days during the month you can get pregnant
- Prevent pregnancy using condoms or not having sex on days you can get pregnant
- Also use condoms to prevent sexually transmitted infections

32

#### Who Can Use

You can use the Standard Days Method if you meet BOTH of these conditions:

- You have your monthly bleeding about once a month, and
- You and your partner can use condoms or avoid sex on fertile days.

#### How to Use

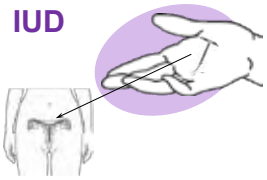
| Move ring to RED bead when period starts. Mark the day on your calendar. | Move ring to next bead every day. Move ring even on bleeding days. | BROWN beads are safe days to have sex (no pregnancy). | Use condoms or do not have sex when ring is on WHITE beads. | When period starts again move ring to red bead to begin again. | Check that your period comes between dark brown bead and last brown bead. |
|---|---|---|---|---|---|

#### What to Expect

- Partners must avoid sex or use condoms for 12 days in a row, every month.
- If monthly bleeding becomes less regular, you need to choose another method.
- Women who recently had a baby or are breastfeeding must wait to have regular cycles before using.

33

### IUD



- Small, plastic "T" wrapped in copper wire placed in the womb
- Stops sperm from reaching egg
- Can be used for up to 12 years
- Must be inserted and removed by trained nurse or doctor
- Use with condoms to prevent sexually transmitted infections

34

#### Who Can Use*

- Safe for all healthy women.
- Can be put in right after giving birth as well as at other times.

#### How It Works

- Prevents sperm from meeting egg.
- Can be removed any time if you want to get pregnant.

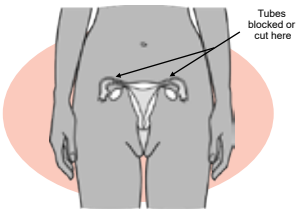
#### What to Expect

- Start any day of the menstrual cycle, if not pregnant.
- May be uncomfortable during insertion.
- May have cramps or menstrual spotting for a few weeks after.

** Can be used as emergency contraception if inserted within 5 days of unprotected sex.*

35

### Female Sterilization




- Permanent method for women and couples who do not want more children
- Woman's tubes that carry eggs to the womb are cut or blocked
- Simple surgery that must be performed by a trained clinical provider
- Use condoms to prevent sexually transmitted infections

36

#### Who Can Use

- Women who do not want any more children.
- Can be done right after having a baby as well as other times.

#### How It Works

- Tubes that carry eggs to the womb are cut. This prevents sperm and egg from meeting.

#### What to Expect

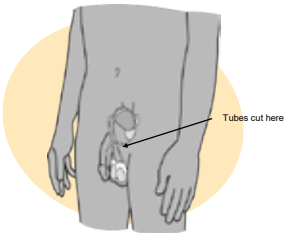
- Local pain killer is given.
- Can go home after a few hours.
- May have soreness for a few days after procedure.
- Monthly bleeding will continue as usual.
- No side effects.

37

# Appendix 3

## CHW Counseling Tool for FP *(continued)*

### Vasectomy




- Permanent method for men or couples who do not want more children
- Tubes that carry sperm to the egg are cut
- Simple surgery that must be performed by a trained clinical provider
- Use condoms to prevent sexually transmitted infections

38

### Who Can Use

- Men who do not want any more children.

### How It Works

- Tubes that carry sperm are cut. This keeps sperm out of semen.
- Testicles are not removed.

### What to Expect

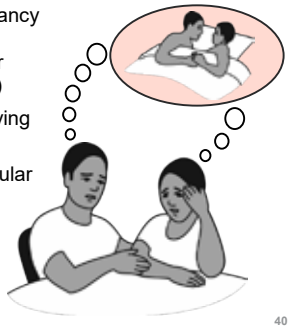
- Local pain killer is given; return home immediately.
- Some discomfort, swelling, and bruising; goes away in 2 to 3 days.
- Does not decrease sex drive, erection, ejaculation, or sexual performance.
- Must use back-up method for first 3 months.
- No side effects.

39

### Emergency Contraceptive Pills (ECPs)

- Pills taken to prevent pregnancy soon after failure of another method, unprotected sex, or cases of rape (up to 5 days)
- Work by preventing or delaying the release of eggs
- Is not a replacement for regular methods

ECPs:
- Do not cause an abortion.
- Will not prevent pregnancy the next time you have sex.

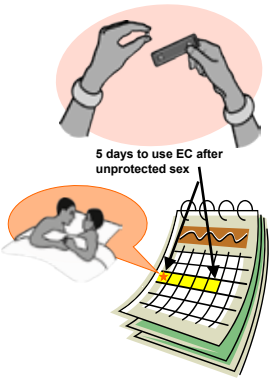


40

### How to Use EC

- Take first pill as soon as possible; take second pill 12 hours later.
- Take up to 5 days after unprotected sex; most effective when used early.
- May cause nausea and vomiting and vaginal spotting or bleeding for a few days.
- Next period may come a few days earlier or later.

*Refer for evaluation if there is a concern that partner has STIs/HIV.*




41

**Screening Checklist for Initiating Injectables—DMPA (IM and SC) and NET-EN**

Ask questions 1–9. As soon as the client answers **YES** to any question, stop, and follow the instructions in the box.

| | | | |
|---|---|---|---|
| NO | 1. Have you ever been told you have breast cancer? | YES | She is not a good candidate for DMPA/NET-EN. Counsel about other methods or refer. |
| NO | 2. Have you ever had a stroke or heart attack, or do you currently have a blood clot in your legs or lungs? | YES | DMPA/NET-EN cannot be initiated without further evaluation. Refer to her to a clinician. Offer condoms to use in the meantime. |
| NO | 3. Do you have a serious liver disease or jaundice (yellow skin or eyes)? | YES | |
| NO | 4. Have you ever been told you have diabetes (high sugar in your blood)? | YES | |
| NO | 5. Have you ever been told you have high blood pressure? | YES | |
| NO | 6. Do you have bleeding between menstrual periods, which is unusual for you, or bleeding after intercourse (sex)? | YES | |
| NO | 7. Have you ever been told that you have lupus? | YES | |
| NO | 8. Do you have two or more conditions that could increase your chances of a heart attack or stroke, such as smoking, obesity, high blood pressure, or diabetes? | YES | |
| NO | 9. Are you currently breastfeeding a baby less than 6 weeks old? | YES | Tell her to return after the baby is six weeks old. |

If the client answered **NO** to all of questions 1–9, she can use DMPA or NET-EN if you made certain she is not pregnant using the checklist on page 8. If the client began her last menstrual period within the past 7 days, she can start DMPA now. No additional contraceptive protection is needed.

If the client began her last menstrual period more than 7 days ago, she can be given DMPA now, but she must use condoms or abstain from sex for the next 7 days. Give her condoms if needed.

**Return to page 23 for How to Use DMPA.**

42

**Screening Checklist for Initiating the Pill (COCs)**

Ask questions 1–12. As soon as the client answers **YES** to any question, stop, and follow the instructions in the box.

| | | | |
|---|---|---|---|
| NO | 1. Are you currently breastfeeding a baby less than 6 months of age? | YES | She is not a good candidate for COCs. Counsel about other methods or refer her to a clinician. |
| NO | 2. Do you smoke cigarettes *and* are you more than 35 years of age? | YES | |
| NO | 3. Have you ever been told you have breast cancer? | YES | |
| NO | 4. Have you ever had a stroke, blood clot in your legs or lungs, or heart attack? | YES | |
| NO | 5. Do you have repeated severe headaches, often on one side, and/or pulsating, causing nausea, and which are made worse by light, noise, or movement? | YES | |
| NO | 6. Do you regularly take any pills for tuberculosis (TB) or seizures (fits)? | YES | |
| NO | 7. Have you given birth in the last 6 weeks? | YES | COCs cannot be initiated without further evaluation. Refer to her to a clinician. Offer condoms to use in the meantime. |
| NO | 8. Do you have gall bladder disease or serious liver disease or jaundice (yellow skin or eyes)? | YES | |
| NO | 9. Have you ever been told you have high blood pressure? | YES | |
| NO | 10. Have you ever been told you have diabetes (high sugar in your blood)? | YES | |
| NO | 11. Do you have two or more conditions that could increase your chances of a heart attack or stroke, such as smoking, obesity, or diabetes? | YES | |
| NO | 12. Have you ever been told that you have lupus? | YES | |

If the client answered **NO** to all of questions 1–12, she can use COCs if you made certain she is not pregnant using the checklist on page 8. If the client began her last menstrual period within the past 5 days, she can start COCs now. No additional contraceptive protection is needed.

If the client began her last menstrual period more than 5 days ago, tell her to begin taking COCs now, but she must use condoms or abstain from sex for the next 7 days. Give her condoms if needed.

**Return to page 25 for How to Use COCs.**

43

# Appendix 3

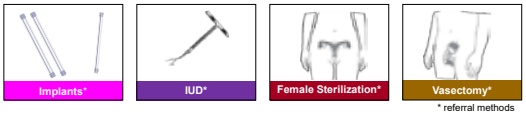
## CHW Counseling Tool for FP *(continued)*

**Come back anytime you have concerns or questions.**

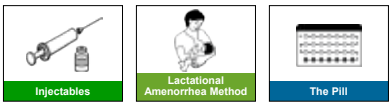
**Thank you.**

**Which method is best for you?**

As you answer the four questions, cover methods that do not work for you.




* referral methods



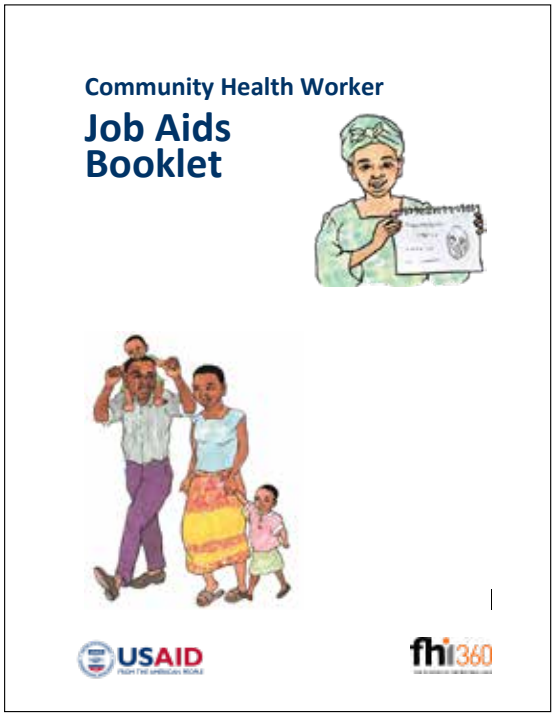

# Appendix 4

## Job Aids Booklet to Support CHW Training and On-the-Job Performance

This is a sample of a job aids booklet suitable for CHWs who are counseling about LAM and the Standard Days Method® (using CycleBeads®), providing condoms, COCs, emergency contraceptive pills, and most recently learning to provide injectables. If CHWs offer other FP methods or services, additional guidance and job aids could be included to support provision of those methods and services. There are notes throughout the prototype document to describe possible adaptations.

The job aids booklet should be distributed at the beginning of the training and used by CHWs during training activities, their practicum and on-the-job. As CHWs become more skilled, they may find that they only refer to the job aids for the complex tasks like determining if a woman is pregnant, eligible to initiate a method, or eligible for reinjection. Some CHWs may find it helpful to affix a tab to the job aids that they use most often.

Reproduced on the next several pages are miniatures of the pages from the job aids booklet. A PDF file of the booklet can be obtained from https://www.fhi360.org/resource/community-based-access-injectable-contraceptives-cba2i-select-resources. The original Word file can be requested from: CBA2I@fhi360.org.





The *Community Health Worker Job Aids Booklet* is a compilation of job aids and guidance from multiple sources that has been periodically updated to maintain technical accuracy. Variations of this prototype have been used in CBA2I programs in multiple countries.

Illustrations by Ambrose Hoona-Kab, Salim Khalaf, and PATH.


Original 2004; revised 2007, 2008

This prototype was made possible by the generous support of the American people through the U.S. Agency for International Development (USAID). The contents are the responsibility of FHI 360 and do not necessarily reflect the views of USAID or the United States Government. Financial assistance was provided by USAID under the terms of these Cooperative Agreements: GPO-A-00-05-00022-0, the Contraceptive and Reproductive Health Technologies Research and Utilization (CRTU) Program; GPO-A-00-08-00001-00, the Program Research for Strengthening Services (PROGRESS) Program; and AID-OAA-A-12-00047, Advancing Partners & Communities (APC).

# Appendix 4

## Job Aids Booklet to Support CHW Training and On-the-Job Performance *(continued)*

### Contents



### Purpose

The *Community Health Worker Job Aids Booklet* is meant to support the tasks that community health workers (CHWs) perform while offering FP services to the members of their community. It is designed to be used in conjunction with a counseling tool that provides information about the available contraceptive method options and leads the client through a series of decisions to ensure that clients make an informed choice about which contraceptive method will best suit their needs. These tools help set the quality standards that CHWs should meet to ensure that the rights of clients are upheld regardless of age, disability, sex, religion, race, culture, or HIV status.

* *If used in conjunction with a counseling tool that includes the pregnancy and method eligibility checklists, omit those from this booklet.*

### Steps for Visits with New Clients—General

1. Make sure you have all the supplies you need.
2. Visit the client, or ask the client to your home, and find a private space to talk.
3. Use your counseling tool to find out the client's goals and concerns. If the client wants to avoid pregnancy or sexually transmitted infections (STIs), counsel about family planning, including emergency contraception, and STI prevention options as indicated. Allow the client to make a choice about which method or options to use.
4. Use the screening checklist to make sure that the client is eligible (for DMPA and COCs only). For other methods, use the Pregnancy Checklist to determine whether the client is may be pregnant and should be referred to a provider for pre-natal and other care.
5. Use your counseling tool to review how to use the client's chosen method and possible side effects of the method.
6. Answer any client questions. If you do not know, refer the client to a provider at the clinic.
7. Give the client the method following the steps for that method (see next page).
8. Make plans for the next visit. Give the client a reminder card.
9. Remind the client to speak with you or visit the health center if there are any problems or questions.
10. Write the information from the visit on the record-keeping forms.



### Steps for Visits with New Clients—Method Specific

*(continued)*

**Condoms**

- Show the client how to put on or insert the condom.
- Ask the client to show how it is done.
- Provide as many condoms as the client needs.

**Pills/COCs**

- Explain what to do when pills are missed.
- Ask client to explain what to do.
- Give client as many pill packs as she needs.

**Injectables**

- Show the client the bottle label and date and the sealed syringe package.
- Explain where the injection is given. Ask the client in which arm she would like to receive the injection. If the woman is very thin or very large, consult with a provider.
- Explain to the client the steps you will follow to give the injection.
- Give the injection following the steps in this booklet.
- Calculate the date of the next injection; 13 weeks for DMPA.

**LAM (breastfeeding)**

- Make sure that the client meets all three criteria; fully breast-feeding, no menses, and less than 6 months since giving birth.
- Discuss which method the client will use when LAM is no longer effective.

**Standard Days Method (CycleBeads)**

- Make sure that the client meets the criteria: regular cycles between 26 and 32 days long and willing to abstain or use condoms for 12 days each month.
- Explain how to use the CycleBeads and the fertility calendar.
- Give the client the beads and the calendar; ask her to explain what to do.

***Adaptation note: Insert steps for all methods that CHWs provide.***



### Steps for Follow-Up Visits—General

1. Make sure you have all the supplies you need.
2. Visit the client, or ask the client to your home, and find a private space to talk.
3. Ask how the client is doing with the method. Ask about any side effects, questions, concerns, or problems to discuss.
4. Ask about life changes that may affect a client's needs; plans for having children, or changes to STI/HIV risk.
5. Ask if there are any new health problems. If yes, check whether the client is still eligible to continue using the current method.
6. Answer any client questions. If you don't know, refer the client to a provider.
7. Perform other method-specific tasks as needed (see next page).
8. Make plans for the next visit.
9. Remind the client to speak with you or visit the health center if there are any problems or questions.
10. Write the information from the visit on the record-keeping forms.

# Appendix 4

## Job Aids Booklet to Support CHW Training and On-the-Job Performance *(continued)*

### Steps for Follow-up Visits—Method Specific
*(continued)*

**Condoms**
- Ask if the client about any problems using condoms.
- Give the client more condoms (recommended number) and review instructions or negotiation skills as needed.

**COCs**
- Ask if she has any problems remembering to take pills or has concerns about side effects.
- Give her more pill packs (recommended number) and review missed pill instructions.
- Review the warning signs of potential complications.

**Injectables**
- Follow the steps in the Reinjection Job Aid in this booklet.

**LAM**
- Ensure the client still meets the three LAM criteria.
- Discuss method to use when LAM is no longer effective.
- Give new method and tell her how to use it and when to start.

**Standard Days Method (CycleBeads)**
- Ask the client if she still meets the criteria: having regular cycles (period starts after reaching the darker brown bead but before the last brown bead) and no issues abstaining or using condoms.
- Review the client's fertility calendar. Note whether her cycles are regular. Ensure that the position of the ring matches the number of days since the start of her last period.

***Adaptation note: Insert steps for all methods that CHWs provide.***



### Preparing for Visits with Clients

**Make sure that you have all the forms, supplies and equipment you need to provide the services and report your activities.**


***Adaptation note: Include a checklist of all supplies that CHWs should have available for every client visit.***



### How to be Reasonably Sure a Client is Not Pregnant

Ask the client questions 1–6. As soon as the client answers **YES** to *any question*, stop, and follow the instructions.

| | | | |
|---|---|---|---|
| NO | 1. | Did your last menstrual period start within the past 7 days?* | YES |
| NO | 2. | Have you abstained from sexual intercourse since your last menstrual period or delivery? | YES |
| NO | 3. | Have you been using a reliable contraceptive method consistently and correctly since your last menstrual period or delivery? | YES |
| NO | 4. | Have you had a baby in the last 4 weeks? | YES |
| NO | 5. | Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then? | YES |
| NO | 6. | Have you had a miscarriage or abortion in the past 7 days?* | YES |

* *If the client is planning to use an IUD, the 7-day window is expanded to 12 days.*

If the client answered **NO** to ***all of the questions***, pregnancy cannot be ruled out using the checklist. Rule out pregnancy by other means. Give her condoms to use until pregnancy can be ruled out.

If the client answered **YES** to ***at least one of the questions*** and she is free of signs or symptoms of pregnancy, you can be reasonably sure she is not pregnant.

* *If the client is concerned about an unintended pregnancy, offer emergency contraception if every unprotected sex act since last menses occurred within the last 5 days.*



### Checklist for Screening Clients Who Want to Initiate Combined Oral Contraceptives

# Appendix 4

## Job Aids Booklet to Support CHW Training and On-the-Job Performance *(continued)*

### Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN)

*Prototype Job Aids Booklet for CHWs—August 2018* 8

### When Can a Woman Start DMPA IM or SC?

Anytime – if you are sure the woman is not pregnant.

During the first 7 days after your client's period starts you can assume that she is not pregnant. You can give an injection now. There is no need for her to abstain or use condoms.

After day seven of her cycle, you must rule out pregnancy before giving an injection.

If she is not pregnant, give the injection and tell her to abstain from sex or use condoms for the next seven days.

The client should return for another injection of DMPA regularly. Coming back every three months (13 weeks).

Postpartum and breastfeeding: wait 6 weeks (follow checklist instructions)

Postpartum and not breastfeeding: anytime within 4 weeks after delivery (after 4 weeks, rule out pregnancy)

Miscarriage or abortion: anytime within 7 days (after day 7, rule out pregnancy)

Switching from another method: start immediately

*Prototype Job Aids Booklet for CHWs—August 2018* 9

### Steps for Giving an IM Injection

1. Wash your hands well with soap and water.

2. Dry your hands with a clean towel or let them air dry.

3. If the skin around the injection site is dirty, clean the site with a cotton ball soaked in clean water.

4. Double-check the bottle for content, dose, and expiration date.

*Prototype Job Aids Booklet for CHWs—August 2018* 10

5. Roll the bottle between the palms of your hands.

6. Hold the bottle of DMPA and remove the plastic cap.

7. Open the sterile package containing the syringe and the needle (if necessary attach needle to syringe).

8. Insert the needle into the rubber cover and empty the entire contents into the syringe.

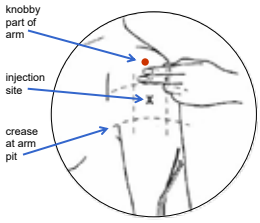
9. Hold the syringe upright and tap on the barrel to move the air into the tip. Expel the air from the syringe gently.

*Prototype Job Aids Booklet for CHWs—August 2018* 11

# Appendix 4

## Job Aids Booklet to Support CHW Training and On-the-Job Performance
*(continued)*

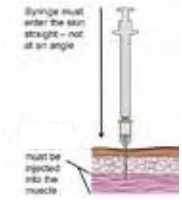
10. Locate the exact site to insert the needle.

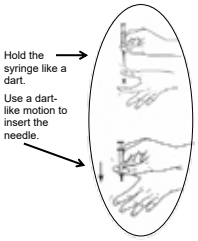



the upper arm

***Adaptation note: Insert illustrations for all injection sites that CHWs are trained to use.***

11. Insert needle straight into the muscle.




*Prototype Job Aids Booklet for CHWs—August 2018* 12

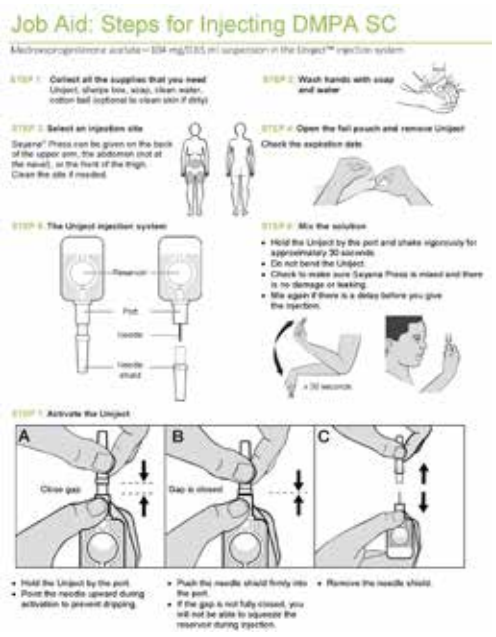
12. Inject DMPA emptying all the contents of the syringe then pull the needle out of the muscle.

13. Gently press the injection site with a clean cotton ball or cloth. Instruct the client not to rub or massage the site.

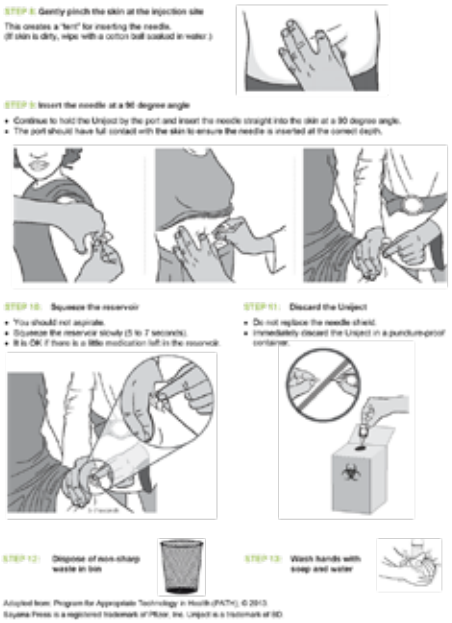
14. Place the used syringe in a puncture-proof safety container. Use great care to avoid a needle-stick injury to yourself or others.

15. Wash hands again with soap and water.

*Prototype Job Aids Booklet for CHWs—August 2018* 13




*Prototype Job Aids Booklet for CHWs—August 2018* 14

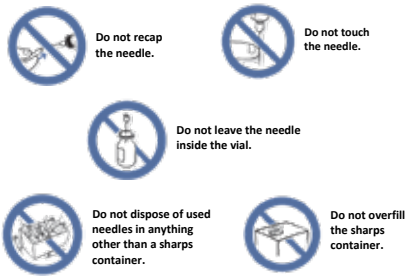


*Prototype Job Aids Booklet for CHWs—August 2018* 15

# Appendix 4

## Job Aids Booklet to Support CHW Training and On-the-Job Performance *(continued)*

### Practice Safe Handling of Needles




***Return the used sharps container to your supervisor or the health care facility.***

**Caring for a Needle-Stick Injury**

- Wash injured area with soap and water as soon as possible.
- Do ***not*** apply other agents (e.g., bleach).
- Contact your supervisor.
- Seek counseling and care at a health facility.



### Checklist for COC Continuation

| | ASK | YES | NO |
|---|---|---|---|
| 1 | Are you satisfied with COCs? | | |
| 2 | Are you able to take your pills every day without missing pills? | | |
| 3 | Have you developed any new serious health problems since last time you visited? | | |
| 4 | Do you have severe headaches that have started or gotten worse since you began taking COCs? | | |
| 5 | Have you started taking any drug for tuberculosis, HIV or epilepsy? | | |
| 6 | Observe if she has yellow eyes or skin | | |

If the client answers **YES** to questions 1 and 2, and **NO** to questions 3 through 6 (all her answers fall into the shaded boxes), re-supply COCs.

If client answers **NO** to questions 1 or 2, find out why she is not satisfied with COCs or has trouble taking her pills every day and help her accordingly. This may also involve helping her to choose another method.

If the client's answers **YES** to questions 3 or 4, or if you observe that she has yellow eyes or skin (**YES** to question 6), give her not more than one pack of COCs to continue and refer for an evaluation by a clinical provider as soon as possible. Clinical provider will determine if she is still a good candidate for COCs.

If the client answers **YES** to question 5, she may be taking drugs, which may cause COCs to be less effective. Counsel the client to use condoms in addition to COCs and refer to a clinical provider who can determine if she can continue taking COCs or should switch to another method which is not affected by the drugs she takes.



***Adaptation note: Include the Job Aid for NET-EN Reinjection if CHWs are providing NET-EN.***

**FOR COMMUNITY-BASED PROVIDERS**

### DMPA Reinjection Job Aid

**STEP 1** Ask the client if she still wants to prevent pregnancy. Then ask if she wants to get another injection.

**STEP 2** Check your records to see when you last gave her an injection.

**STEP 3** If today is her scheduled return date, go to Step 4. If she is early or late for her injection, look at a calendar to find out if she is within the reinjection window.
- Instructions to find out whether a client is within the reinjection window are in Box 1 on page 2 of this job aid.

**STEP 4** Explain that women with certain serious medical problems should not get the injection. Ask her whether a doctor or nurse has told her she has a medical problem.
- If she has a medical problem, go to Box 3 on page 2.
- If she has not been told she has a medical problem, go to Step 5.

**STEP 5** Give her the injection.
- Follow the steps for safe injection you learned in training.

**STEP 6** Talk to her about side effects.
- Remind her that changes to bleeding, such as heavy or irregular bleeding and eventual amenorrhea, are normal and not harmful. Talk to her about what to do if she has questions or does not feel well.
- Refer her to the health center for care of any side effects that are a problem for her.

**STEP 7** Look at the calendar to plan the date for her next injection. This will be 13 weeks from today. Remind her of the importance of coming back on time and discuss how she will remember.
- Remind her that she can talk with you, a doctor, or a nurse if she has any questions or problems.
- Tell her that if she is ever more than 4 weeks late for an injection, she should use condoms or not have sex until she gets another injection.

**STEP 8** Remind her that the injection will not protect her from HIV or other STIs.
- Tell her to use a condom in addition to the injection if she is at risk.

**THE REINJECTION WINDOW**

During the **reinjection window** you can safely give your client the injection without checking if she is pregnant. Your client is in the reinjection window if she returns up to:

14 days (2 weeks) early

or

28 days (4 weeks) late

*See Box 1 on page 2.*


**What if she is not within the reinjection window?**

You will need to ask her questions to make sure she is not pregnant before you can give her the injection.

*See instructions in Box 2 on page 2.*



**BOX 1**

**How can I tell if a client is within the reinjection window?**

A client is within the reinjection window—and can get another injection—if she is up to 14 days (2 weeks) early or up to 28 days (4 weeks) past her scheduled return date. If she is up to 4 weeks late, you do not need to check if she is pregnant before giving her another injection.
- If she is within the reinjection window, go to Step 4 on page 1.
- If she is past the reinjection window, follow the steps in Box 2 below.

**BOX 2**

**What if a woman wants another injection but she is more than four weeks late?**

If a client is more than 4 weeks late for her scheduled reinjection, she can still get another injection today if you can make sure that she is not pregnant. Use the steps below to decide if you can reasonably rule out pregnancy and give her the injection.

**FIRST,** look at a calendar and find her scheduled reinjection date. Count forward 4 weeks to find the last day of her reinjection window. Show her this date on the calendar and tell her to keep it in mind when you ask the four questions below.

**NEXT,** make sure she is not pregnant by asking these four questions:

1. Have you had no sex since the last day of your reinjection window?
2. Have you been using condoms or another method every time you had sex since the end of your reinjection window?
3. Did you have a baby less than 6 months ago, are you fully or almost fully breastfeeding, and have you had no period since then?
4. Have you used emergency contraceptive pills after every sex act since the end of your reinjection window?

If the client answers **YES** to **ONE OR MORE** of these questions, she is probably not pregnant, give her an injection. Tell her to have no sex or use condoms for 7 days. After 7 days, the injection will keep her from getting pregnant. **Go to Step 4** on the first page of this job aid.

If the client answers **NO** to **ALL FOUR** questions, tell her to see a doctor or nurse to rule out pregnancy before she gets another injection. Remind her to use a back-up contraceptive method until she gets the next injection.

**BOX 3**

**Does my client have a medical problem that would make it unsafe for her to get the injection?**

Ask her whether a doctor or nurse has told her she has developed a serious medical problem with her head, heart or liver, or whether she was diagnosed with breast cancer.

If your client has not had a doctor or nurse tell her she **has a serious medical problem, she most likely does not have a medical condition that would make it unsafe for her to continue using DMPA. Go to Step 5.**

**If she has a serious medical problem with her head, heart or liver, or has been diagnosed with breast cancer, do not give the injection. Refer her to a doctor or nurse who** can counsel her on the contraceptives she can use with her medical condition. Remind her to use a backup method (like condoms) until she sees the provider.

Source: World Health Organization/Department of Reproductive Health and Research (WHO), Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs/INFO Project (CCP). *Family Planning: A Global Handbook for Providers*. Baltimore, MD and Geneva: CCP and WHO; 2018 update.

## Job Aids Booklet to Support CHW Training and On-the-Job Performance
*(continued)*

### Calendars for Calculating Reinjection Dates


***Adaptation note: Use this template to create additional calendars.***
https://templates.office.com/en-US/Calendar-creator-any-year-TM10274124



### Contact List for Referral Services

*In the spaces below, record contact information for services that are available to clients in the community where you work. When referring clients for services that you cannot provide, be sure to explain: where to go, when to go, whom to see, directions to the facility, distance involved, transportation options, how much time to allow for the visit, what to take to the visit, and any costs for services. Also provide a referral form that includes clear instructions for the client.*

| | |
|---|---|
| Testing and treatment for STIs | HIV support group(s) |
| Counseling and testing for HIV | Psychological support |
| ARV therapy | Home-based care |
| Antenatal/PMTCT | Child health and parenting |
| Family planning (clinical methods) | Men's health |
| Infertility treatment | Adolescent program |
| Management of abortion-related complications | Domestic violence or rape crisis |
| Other sexual and reproductive health (cancer screening and treatment) | Alcohol and drug abuse |
| Infant feeding support (i.e., milk bank, formula, breastfeeding coaching) | Legal and financial support |
| Nutritional counseling and support | Pharmacy |

***Adaptation note: Adapt to match the services available in the community.***



### Note-taking Pages

*Use this space to write important information that you do not want to forget.*

# Appendix 5

## Evaluating CHW Performance of Counseling and IM/SC Injectables Provision

The **skills checklist** is the primary tool for determining whether a CHW has the skill set required to provide injectable contraceptives to standard. The skills checklist can be used by CHWs during training when they are practicing new skills, by practicum supervisors to determine if a CHW is ready to provide injectable contraceptives without direct supervision, and by supervisors during periodic visits with CHWs to ensure that skills are maintained. The checklist is broken into categories that reflect the major stages of a typical FP/RH-related interaction between a CHW and a client. Each category lists step-by-step/discrete tasks to facilitate recording observations, providing feedback, noting areas that require additional practice, and recording progress over time. Data from the skill checklists may be reviewed periodically to ensure quality standards are maintained in the CBFP program.

Some programs use a **knowledge test** to assess whether community health workers have an understanding of concepts which cannot not be readily observed during a skills test. Rather than dedicating a training session to administer a knowledge test, consider incorporating the test questions into the training activities where these concepts are being learned. Interactive question-and-answer games and group discussions allow learners to ask questions, share ideas and gain a broader understanding of the concepts, and permit trainers to observe whether learners are fully comprehending the issues. Written knowledge tests—especially those administered in a non-native language—can be challenging for CHWs with limited literacy. If a knowledge test is included, it should not be the only assessment used to determine whether a CHW is capable of providing injectables.

# Appendix 5

## Checklist for Evaluating CHW Counseling and IM/SC Injectables Method Provision

**CHW:** _____ **Client:** _____

**Observation #** _____ **Supervisor/Preceptor:** _____ **Date:** _____

**Client's permission to participate in practicum obtained:** _____ **client's initials** _____ **supervisor's initials** _____

| | Yes | No | N/A |
|---|---|---|---|
| **Overall: Communicate Effectively and Maintain Rapport** | | | |
| Shows respect and avoids judging client | | | |
| Maintains relaxed, friendly and attentive body postures and eye contact | | | |
| Uses simple, clear language | | | |
| Uses open-ended and probing questions correctly | | | |
| Listens carefully to client (paraphrases and reflects) | | | |
| Asks client about feelings (and shows empathy) | | | |
| Describes client's roles/responsibilities for the session | | | |
| Encourages client participation | | | |
| Explains what will occur during visit and procedures | | | |
| Ensures client understanding and corrects misunderstandings | | | |
| Uses job aids appropriately | | | |
| Correctly records information on data-collection forms | | | |
| **Establish Rapport and Assess Client's Needs and Concerns** | | | |
| Greets client appropriately | | | |
| Ensures confidentiality and privacy and that client is comfortable | | | |
| Asks about reason for visit | | | |
| Asks about client's partner(s), children, family, sexual behavior, health | | | |
| Asks about plans to have children, desire for FP (e.g., spacing, limiting) | | | |
| Explores STI risk and what client does to avoid STIs | | | |
| **Provide Information to Address Client's Identified Needs and Concerns** | | | |
| Informs client when needs/concerns are beyond CHW capability | | | |
| Advises on preventing STIs (i.e., abstain, fewer partners, use condoms) | | | |
| Explains benefits of FP and healthy spacing | | | |
| Helps client identify FP methods suited to her or his needs | | | |
| Gives information on FP methods of interest | | | |
| Responds to other client questions or concerns | | | |

| | Yes | No | N/A |
|---|---|---|---|
| **Help Client Make an Informed Decision or Address a Problem** | | | |
| Asks client if he or she has any questions about methods of interest | | | |
| Asks client to choose a method | | | |
| Uses screening checklist to determine if client can use the method | | | |
| Agrees on decision or plan in partnership with client | | | |
| **Help Carry Out Client's Decision** | | | |
| Gives contraceptive method and condoms for dual-method use, if needed | | | |
| Explains and/or demonstrates correct use | | | |
| Asks client to explain or demonstrate correct use, and reinforces client's understanding and/or corrects client's demonstration | | | |
| Reminds client about side effects and reasons for returning | | | |
| Gives supplies (as needed) | | | |
| Role plays or rehearses negotiation skills and helps client plan approach | | | |
| Arranges follow-up, resupply, and referral to outside services, as needed | | | |
| **Tasks specific to providing DMPA IM or NET-EN** | | | |
| 1. Ask client where she would like to receive the injection | | | |
| 2. Show sealed bottle and expiration date on label to client | | | |
| 3. Wash hands well with soap and water | | | |
| 4. Dry hands with a clean towel or let them air dry | | | |
| 5. If skin is dirty, clean injection site with water-soaked cotton ball | | | |
| 6. Double-check the bottle for content, dose, and expiration date. | | | |
| 7. Roll bottle between palms or shake gently (DMPA only) | | | |
| 8. Remove plastic cap from bottle | | | |
| 9. Open sterile package for syringe/needle (attach needle if needed) | | | |
| 10. Fill syringe with contents of the bottle | | | |
| 11. Expel air from syringe | | | |
| 12. Locate the exact site for injection | | | |
| 13. Insert needle straight into the muscle | | | |

# Appendix 5

## Checklist for Evaluating CHW Counseling and IM/SC Injectables Method Provision *(continued)*

**Observation # _____**

| **Tasks specific to providing DMPA IM or NET-EN** *(continued)* | Yes | No | N/A |
|---|---|---|---|
| 14. Inject the entire contents of the syringe | | | |
| 15. Gently press the injection site with a clean cotton ball | | | |
| 16. Place the used syringe into the sharps container.* | | | |
| 17. Place non-sharps waste in bin | | | |
| 18. Wash hands with soap and water | | | |
| 19. Instruct the client not to massage the site | | | |
| 20. Calculate reinjection date (13 weeks DMPA; 8 weeks NET-EN) | | | |
| **Tasks specific to providing DMPA SC** | | | |
| 1. Ask client where she would like to receive the injection; the back of the upper arm, the abdomen (not at the navel), or the front of the thigh | | | |
| 2. Wash hands well with soap and water. | | | |
| 3. Dry hands with a clean towel or let them air dry | | | |
| 4. If skin is dirty, clean injection site with water-soaked cotton ball. | | | |
| 5. Open the pouch by tearing the notch. | | | |
| 6. Check expiration date and show it to client. | | | |
| 7. Hold the Uniject by the port | | | |
| 8. Shake Uniject vigorously for 30 seconds. | | | |
| 9. Check to make sure the solution is mixed and there is no damage or leaking | | | |
| 10. Hold the Uniject by the port and keep it pointed upward to prevent spilling the drug during activation | | | |
| 11. Push the needle shield and port together to fully to activate the device for use | | | |
| 12. Remove the needle shield | | | |
| 13. Pinch the "skin" at injection site to form a tent | | | |
| 14. Hold port and insert needle straight into the skin at a 90 degree angle until port touches the skin | | | |
| 15. Move fingers from the port to the reservoir while still pinching the skin | | | |
| 16. Press the reservoir slowly to inject the contraceptive (about 5–7 seconds) | | | |
| 17. Place the used Uniject into the sharps container; do not replace the needle shield.* | | | |
| 18. Place non-sharps waste in bin | | | |
| 19. Wash hands with soap and water | | | |
| 20. Instruct the client not to massage the site | | | |
| 21. Calculate reinjection date (13 weeks DMPA). | | | |

* Ask CHW to explain the procedure for managing disposal of sharps containers.

Specific Notes/Observations Regarding CHW Performance

Overall Score for this Observation

_____ Passed

_____ Failed

CHW signature: _____

Trainer/Supervisor signature: _____

Appendix 6

# Guidance for Monitoring and Evaluation of Community-Based Access to Injectable Contraception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# Appendix 6



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# Appendix 6

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

### 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.

#### *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.

[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/.

# Appendix 6

**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**

# Appendix 6

## 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.

# Appendix 6

## 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<br>5 days practicum |
| Malawi | 10 weeks | 2 days theory<br>3 days practicum |
| Uganda | 1 week | 7-10 days<br>(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.

# Appendix 6

***Current indicators***

**Senegal**

# of clients counseled
- 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

**Uganda**

# 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

**Malawi**

# of women receiving a method
- # 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.

# Appendix 6

***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 124-125.)

- 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, Taegtmeyer 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.

# Appendix 6

## 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 124-125, 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 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | DD/MM/YY | 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. | | | | | | | | | | | | | | | | | | | | |
| 4. | | | | | | | | | | | | | | | | | | | | |
| 5. | | | | | | | | | | | | | | | | | | | | |
| 6. | | | | | | | | | | | | | | | | | | | | |
| 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: _____

## Commodities Tracking Form for CHW Program

Contraceptives Distributed by CHWs

Month/year reported: Jan /2018

| CHW Name | Date DD/MM/YYYY | Products | | | | | | Other | | | | Educational Materials |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | DMPA + syringe | DMPA-SC | COC | ECP | Condoms | | Safety Boxes | | Cotton swabs | Cycle beads | |
| | | | | | | Male | Female | Returned | Issued | | | |
| A. Banda | 1/1/2018 | 9 | 4 | 12 | 2 | 240 | 15 | 1 | 1 | 22 | 2 | |
| J. Mwangi | 3/1/2018 | 9 | 5 | 10 | 2 | 300 | 0 | 1 | 1 | 25 | 3 | |
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| Totals: | | | | | | | | | | | | |

This form helps CHW supervisors and facilities track the number of commodities used in the last month for purposes of resupply and to avoid stock-outs.

The total number of each type of product/commodity distributed that month by each CHW is entered. Data is compiled by the facility and used to re-order supplies.

Remarks:

_____

_____

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

Signature of CHW supervisor: _____ Date form submitted: _____

# Appendix 6

## 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.<br>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.<br>Numerator: 1.3<br>Denominator: 1.1 |
| 2.1/2.2 (Supervision) | #/% 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 | Appropriate length of time after training to be defined by in-country standards<br>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.<br>Looking at those certified during the previous reporting period allows enough time to have passed for the opportunity of supervision to have occurred.<br>Supervision should include both counseling and injection skills, cover reiterative skills, and address gaps.<br>Numerator: 2.1<br>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.<br>Numerator: 3.6<br>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:<br># of clients new to family planning (FP) (first FP use ever)<br># of clients new to the method, but had previously used FP<br># of resupply injections<br># of on-time injections (within grace period) |

# Appendix 6

| 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 (#)<br>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 | 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.<br><br>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.<br><br>Numerator: 1.3<br>Denominator: 1.1 |
| 1.5 (#)<br>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<br>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 | Disaggregation:<br># of initial training courses for providers held<br># of train-the-trainers courses held<br># of refresher courses held<br># of participants<br><br>This indicator helps monitor whether training happens, how often, and the number of attendees. |

# Appendix 6

| | | | |
|---|---|---|---|
| **Supervision** | | | |
| 2.1 (#)<br>2.2 (%) | **#/% 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** | #/% 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 | 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.<br>Looking at those certified during the previous reporting period allows enough time to have passed for the opportunity of supervision to have occurred.<br>Supervision should include both counseling and injection skills, cover reiterative skills, and address gaps.<br>Numerator: 2.1<br>Denominator: 1.5 |
| 2.3 (#)<br>2.4 (%) | #/% 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* | Adequate skills determined by each country/program<br><br>#/% of those supervised who demonstrated adequate skills; adequate skills determined by each country/program | Numerator: 2.3<br>Denominator: 2.1 |
| **Readiness** | | | |
| 3.1 (#)<br>3.2 (%) | #/% of CHWs certified in providing injectable contraception who have given an injection in the last quarter | #/% of CHWs certified in providing injectable contraception who have given a client an injection in the last quarter<br>To avoid double counting CHWs, this indicator should not be added to previous quarters, but rather compared with them. | Include not only those trained and certified in the reporting period but also all certified and active CHWs.<br>The denominator would include all active, certified CHWs, not only those who were certified in the reporting period.<br>Numerator: 3.1<br>Denominator: Total # of certified CHWs |
| 3.3 (#)<br>3.4 (%) | #/% of villages/catchment areas with a CHW certified to provide injectable contraception | #/% of villages/catchment areas with a CHW certified to provide injectable contraception<br>Catchment area defined by each program/country | Numerator: 3.1<br>Denominator: Total # of villages/catchment areas |
| 3.5 | # of households served per CHW | The average number of households served by each CHW. | Numerator: Number households in a catchment area in the reporting period.<br>Denominator: Total number of active CHWs in the catchment area in the reporting period. |

# Appendix 6

| | | | |
|---|---|---|---|
| 3.6 (#)<br>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.<br><br>Numerator: 3.6<br>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:<br># of clients new to FP (first FP use ever)<br># of clients new to the method, but had previously used FP<br># of resupply injections<br># 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 (#)<br>5.2 (%) | #/% of CHWs submitting data reports on time | #/% of CHWs submitting data reports on time<br><br>"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.<br><br>Numerator: 5.1<br>Denominator: 3.1 |
| 5.3 (#)<br>5.4 (%) | #/% of CHWs submitting complete client data reports | #/% of CHWs submitting reports with at least 80% of data points complete | Numerator: 5.3<br>Denominator: 3.1 |
| 5.5 (#)<br>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<br>Denominator: 3.1 |


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