Family planning and comprehensive abortion care toolkit for the primary health care workforce

Volume 3

Dissemination, implementation, monitoring and evaluation (DIME)

World Health Organization

human reproduction programme hrp
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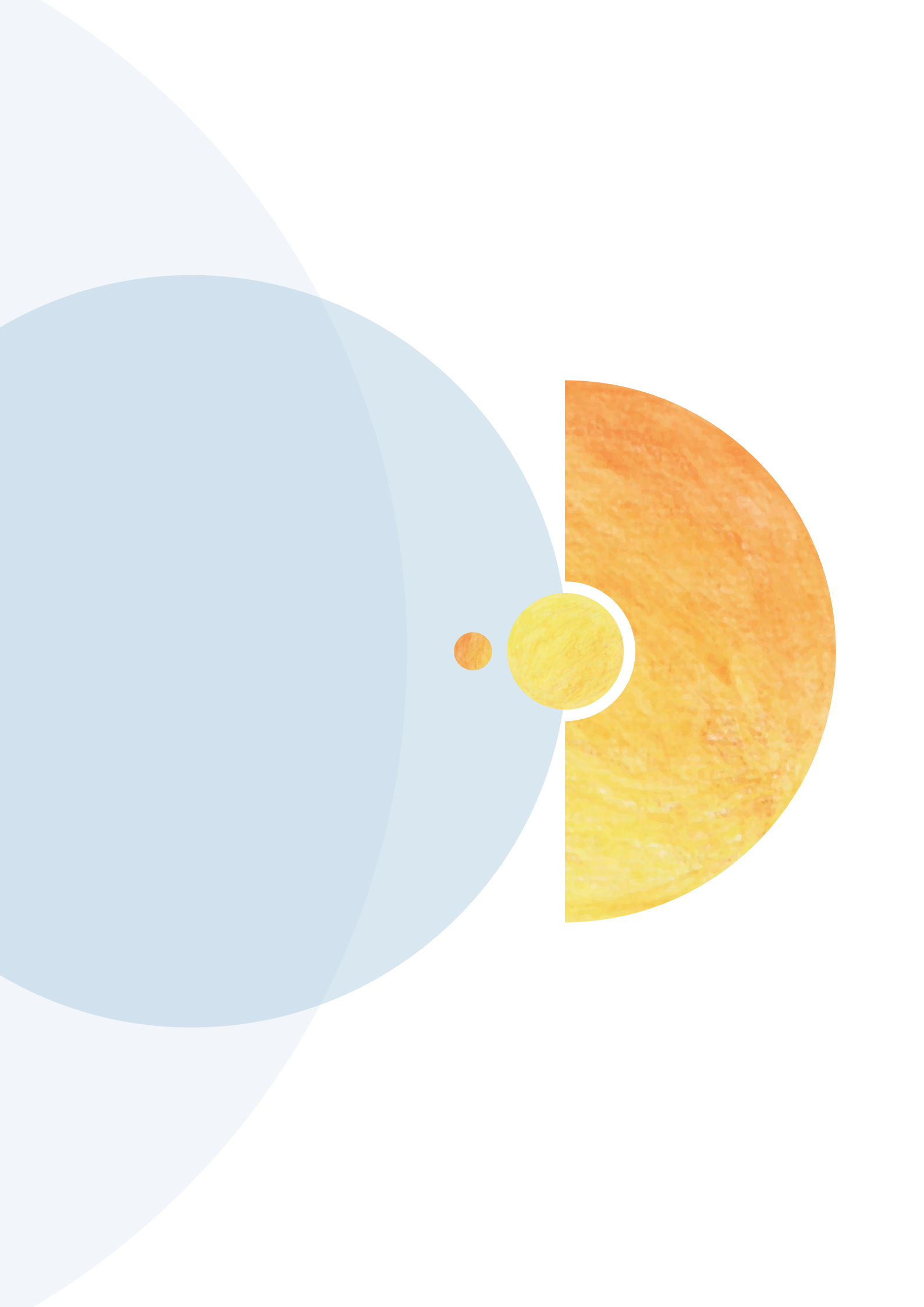
Abbreviations

CAC	comprehensive abortion care
CBE	competency-based education
DIME	dissemination, implementation, monitoring and evaluation
FP	family planning
M&E	monitoring and evaluation
NGO	nongovernmental organization
PHC	primary health care
UHC	universal health coverage
UNFPA	United Nations Population Fund
WHO	World Health Organization



Introduction

Volume 3 of the toolkit

This document, *Dissemination, implementation and monitoring and evaluation (DIME) guide*, is the third volume of the *Toolkit on family planning and comprehensive abortion care for the primary health care workforce*. The toolkit aims to enhance the capacities of the primary health care (PHC) workforce in terms of their competencies to provide family planning (FP) and comprehensive abortion care (CAC) services and thus to enhance the quality of care provided to women and girls.

WHO definition of competencies

Abilities of a person to integrate **knowledge, skills and attitudes** in their performance of tasks in a given context. Competencies are durable, trainable, and, through the expression of behaviours, measurable *(1)*.

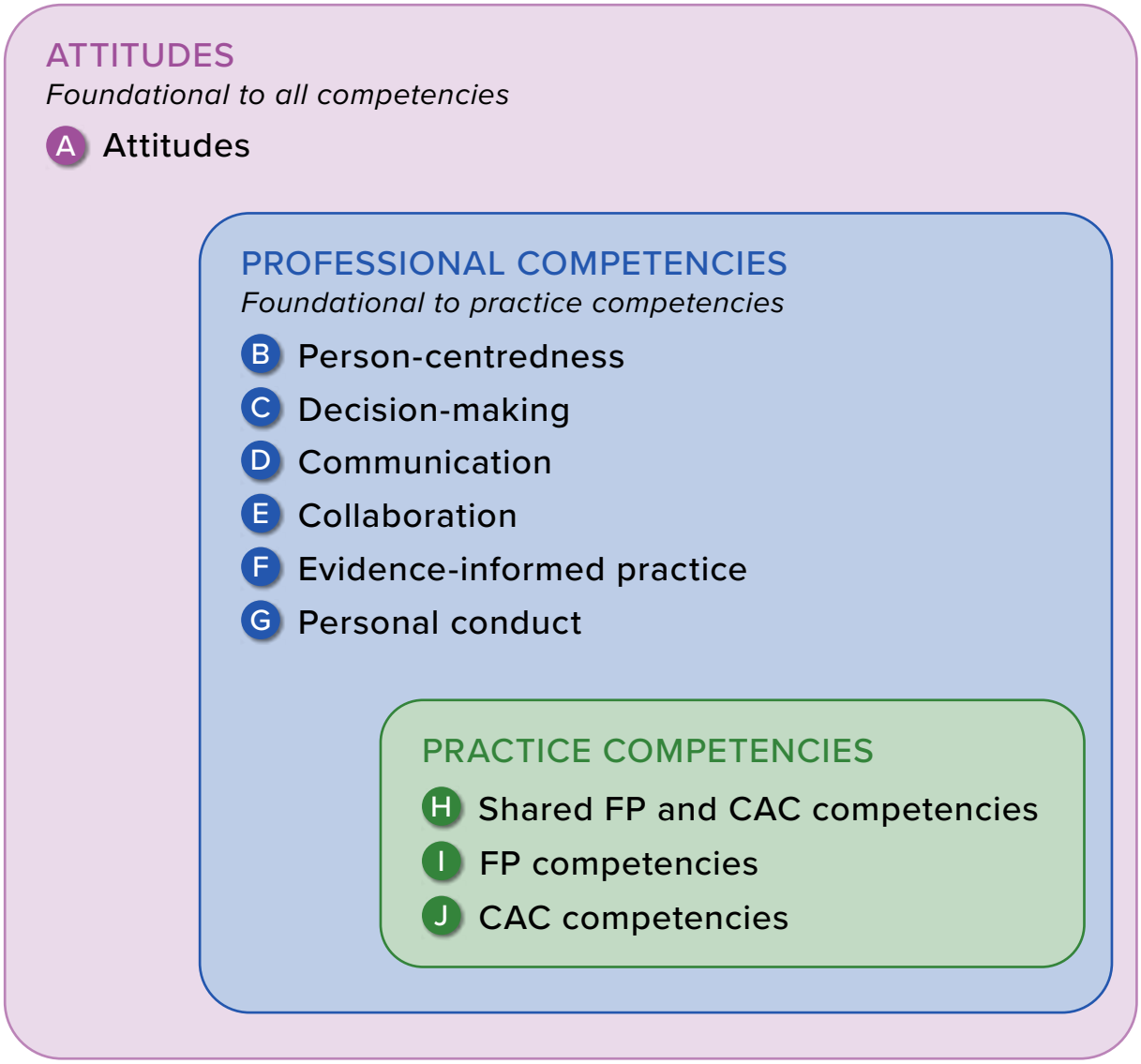
The toolkit makes use of competency-based education (CBE) – a learner-centred and outcome-based approach that prepares participants for capable practice. It provides health workers with the required knowledge, skills and attitudes to provide quality FP and CAC services within the broader efforts to achieve universal health coverage (UHC). Rather than being time-based, as regular training approaches are, CBE is informed by an analysis of societal, learner and service-user needs and, thus, provides greater accountability and flexibility while putting learners at the centre of the approach.

Competency-based education (CBE) in training the health workforce

Competency-based education and practice are a model to improve education, training and performance of the health workforce. CBE outcomes concern the desired attributes in health workers, standardizing performance requirements and thus enabling trainees to better serve their communities *(2–4)*. There has been a growing need to develop and use competency frameworks in health training in response to growing concerns about social accountability, patient safety and the cost–effectiveness of medical education programmes *(3)*.

The health workforce and its capacity are at the centre of every health system. However, health workforce challenges – including shortages, inequitable distribution, and gaps in the competencies and performance of health workers – negatively affect progress towards UHC, global health security and the health-related Sustainable Development Goals (SDGs) *(5)*. For the health workforce to deliver on expected competencies to be able to provide services that meet population health needs over time, assessments of competency training and of performance gaps are required. The FP and CAC competencies that can guide competency-based training initiatives are presented in Figure 1.

Figure 1. Domains of FP and CAC competencies for the primary health care workforce



The other volumes of the *Family planning and comprehensive abortion care toolkit for the primary health care workforce* include:

- *Volume 1: Competencies (1)*
- *Volume 2: Programme and curriculum development guide (6)*

This DIME volume provides information and tools in three areas of FP and CAC competency development.

1. **Dissemination:** Ways in which the CBE approach can be shared across relevant health and education stakeholders.
2. **Implementation:** How the competencies can be used by different stakeholders to enhance the quality of FP and CAC service delivery.
3. **Monitoring and evaluation:** Ways in which the implementation process, its outputs, outcomes and impacts can be assessed to address challenges identified, learn lessons for improvement, and enhance performance and results.

Purpose of the DIME volume

Accelerating awareness, uptake and use of the FP and CAC competencies is of prime importance and is the purpose of this third volume of the toolkit. CBE and continuing professional development provide the most effective means to promote improved performance of the PHC workforce in delivering effective, high-quality FP and CAC services that meet population health needs. This DIME volume will support dissemination of the competencies, including their use as an advocacy tool to support provision of the legal, political and budgetary requirements, thereby providing an enabling environment for CBE. This volume also supports the implementation of the FP and CAC competencies by a variety of stakeholders in the health and education sectors. Through inclusion of monitoring and evaluation, users will be enabled to adapt the implementation process by using evidence of results achieved, challenges identified and lessons learned, and, in this way, enhance the impact.

Expected users

This volume is meant to be used by all stakeholders involved in developing, implementing and assessing competencies in the provision of FP and CAC services. These stakeholders can include health service practitioners, managers and regulators; educators and health- and education-related policy-makers; and multilateral agencies and civil society organizations supporting health- and education-related initiatives. Each of the stakeholders is expected to make different use of this volume. While policy-makers may focus on putting the conditions in place for the development of the competencies, their implementation, monitoring and evaluation, educators and health service providers may have a more hands-on approach to the use of the volume. Table 1 gives details of different kinds of uses by different stakeholder groups.

Table 1. Application of the FP and CAC toolkit by different stakeholders

Stakeholder	Application of the toolkit
Ministry of health	Ensure the policy environment of health-related policies and development plans includes an emphasis on CBE for FP and CAC and that the means are in place to assess its contribution to health sector results
Ministry of education	Ensure the enabling environment of education-related policies and development plans includes an emphasis on CBE for FP and CAC and that the means are in place to assess its contribution to health workforce capacities
Health regulator	Advocate, plan, assess, and develop licensing and regulatory mechanisms for the health sector, including the need for CBE of health workers
Health educator	Develop and use competency-based curricula in response to identified population and health needs for pre- and in-service training, including for use of internships and residencies, and assessment of results in terms of enhanced skills, behaviour and aspects of attitudes
Health service manager	Plan, assess and prioritize FP and CAC competency training, providing the resource environment in different health-care facility settings as part of the continuing professional development of the health workforce, and incorporate the competencies in staff performance reviews
Health provider	Enhance FP and CAC competencies informed by assessment of competency gaps as part of continuing professional development, making use of the FP and CAC competencies in their daily work to provide quality services
Multilateral health-related agency	Support the use of the FP and CAC competencies, including in the design, monitoring and evaluation of supported health-related programmes and initiatives at national and subnational levels
Professional organization related to sexual and reproductive health and rights (SRHR)	Support the dissemination to ministry of health and other relevant policy-makers; support implementation of the competencies by members and partners, medical schools and health-care facilities; and contextualize the competencies
Health-related international nongovernmental organization (NGO)	Use the FP and CAC competencies in the design, monitoring and evaluation of health-related programmes and initiatives in support of national and subnational health-related policies and plans
Civil society organizations of service-users (e.g. women's organizations, student organizations)	Contextualize the competencies at country and local levels and support their implementation
Pregnant and lactating women	Make use of FP and CAC services and benefit from enhanced quality of services in line with the competencies

CAC, comprehensive abortion care; CBE, competency-based education; FP, family planning.

Use of this volume is expected to facilitate the implementation of the competencies in health-care delivery and provide data on their use and the results that they contribute towards. In this way, use of this volume will enhance evidence-based practice and improve the quality of care. The competencies are an important component of continuing professional development and their application can increase consistency in terms of a competent health workforce, enabled to provide quality care and continue to improve the quality of care.

Why do competency-based education and practice matter?

CBE provides a way to improve training and enhance the practice and performance of the health workforce. Development and use of competencies in health training is a necessary response to growing concerns about social accountability, patient safety and the cost–effectiveness of medical education programmes *(3)*. An example concerns the review of the *State of the world's nursing*, which included the policy recommendation for countries to ensure that nursing education and training programmes equip nurses with competencies to deliver high-quality, integrated, people-centred services and for health education institutions and regulators to adopt competency-based curricula *(7)*.

Benefits of CBE

CBE:

- helps standardize training materials and ensures that training is based on a standardized procedure;
- clearly articulates performance expectations to learners so they understand exactly what is expected of them;
- breaks down and highlights the specific elements of a task or skill that need improvement;
- enhances learner recall by focusing on participatory (rather than passive) methods of learning;
- provides trainers with the opportunity to coach and encourage learners, rather than only instructing and lecturing;
- ensures all participants have their skills measured objectively and according to the same standard;
- functions as a self- or peer-assessment tool;
- provides a basis for follow-up evaluations of trained clinicians *(8)*.

Tailoring the competencies to local needs and contexts

The FP and CAC competencies outline the expected capacities and related practices of health workers across a wide range of jobs, professions, specializations, environments, patients/clients and in diverse settings, with the aim of providing quality services and care. The competencies were developed to support a variety of stakeholders in all parts of the world to address challenges in performance of FP and CAC services.

Most stakeholders are aware of the opportunities of using competencies to improve education and practice in the health sector, but the global and generic competencies need to be tailored to national and local needs to enable adoption and use. While competencies have been shown to be important means for enhancing health workforce capacities and to contribute to improving the health of local communities, the greatest gains occur through tailoring and ownership of such competencies.

As such, the competencies provide a menu of options, from which organizations, institutions and service providers can choose the set of individual competencies they require to focus on. They may identify a tailored set of competencies aligned with national or local-level health requirements and capacity gaps in the workforce. Specific language of the FP and CAC competencies can be adapted to local contexts.[1]

Steps to be taken

Table 2. Steps to be taken to adopt the competencies and instruments for use in each step

	Step	Instrument[a]
1	Identify and assess stakeholders	1: Assessment of level of engagement of each of the stakeholders with the FP and CAC competencies
2	Development of a dissemination plan	2: Stakeholder dissemination plan
3	Assessment of capacities of the user organizations	3: Capacity assessment of user organizations
4	Assess key attributes of the use of the competencies that can enhance successful adoption	4: Attributes for implementation of the competencies, key questions and identification of follow-up
5	Assessment of the external environment and external enabling and constraining factors	5: Assessment of public enablers and constraints for implementation of the competencies
6	Development of the implementation strategy, tailored to the needs, capacities and external context of the organization targeted	6: Contents of the implementation strategy document
7	Development of the monitoring and evaluation plan	7: Contents of the M&E plan
8	Development of the results framework	8: Components of the results framework
9	Learning during the process of implementation	9: Learning tool on the expansion of use of the FP and CAC competencies

CAC, comprehensive abortion care; FP, family planning; M&E, monitoring and evaluation.

[a] See Annex for Instrument details.

1. For details on adaptations, see *Volume 2: Programme and curriculum development guidance*, Phase 3, Step 7, p 26–29 *(6)*.

How was this volume developed?

This volume of the toolkit was developed with inputs from:

- focus group discussions and interviews with key stakeholders from WHO, academic and training institutions, professional associations, independent consultants, ministries of health and nongovernmental organizations (NGOs);
- a literature review of competency-based education and practice, which included WHO guidelines and tools, internet sites, journal articles and “grey” literature.

Dissemination

Assessment of stakeholders to involve

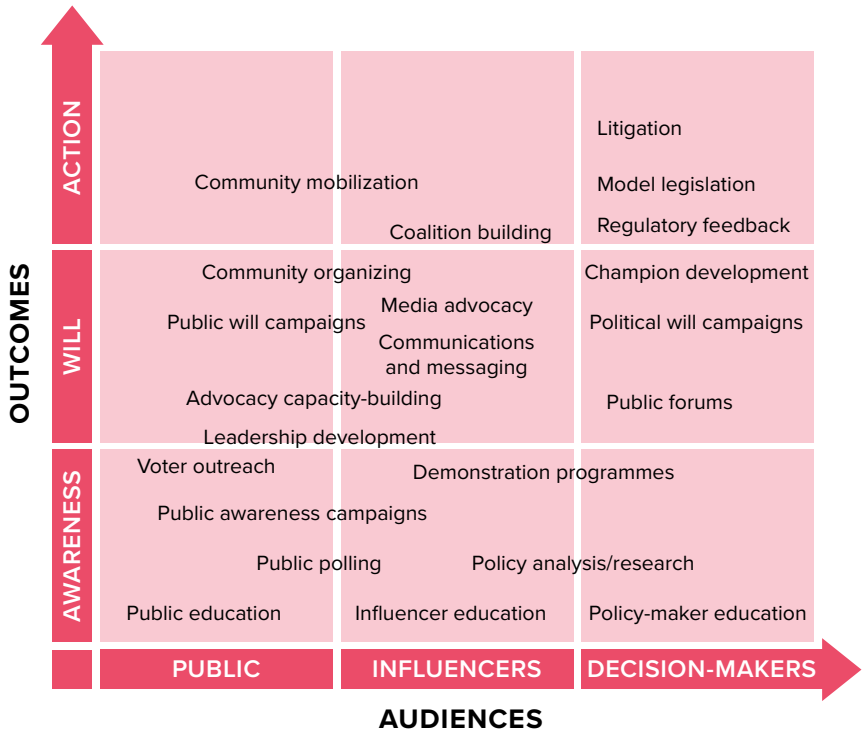
Step 1: Identify and assess stakeholders

Target audiences for the dissemination of the FP and CAC competencies and the advocacy for their use range from national-level ministries to health regulators, service managers and health-care providers, professional, multilateral and civil society organizations (see Table 1). The aim of the engagement with these stakeholders includes gaining their buy-in and development of leadership on the issues concerned, awareness-raising and capacity development.

For each of these stakeholders it will be important to establish their familiarity with CBE and the FP and CAC competencies in particular. This includes their awareness of, and knowledge and willingness to make use of, competencies in PHC workforce capacity development. For this assessment, use can be made of **Instrument 1**: **Assessment of level of engagement of each of the stakeholders with the FP and CAC competencies**.

Instrument 1 provides a set-up for an initial assessment of each stakeholder identified in terms of the role that they play, their understanding of the competencies, and their commitment to using them in public health education and practice. Thus, the instrument specifies, for each stakeholder, their level of awareness of the competencies, their knowledge of them and their willingness to implement them (for details, see Fig. 2).[2]

Figure 2. Advocacy strategy framework



2. While in the generic Advocacy Strategy Framework presented in Figure 2 reference is made to awareness on the vertical axis, this can be conceived in terms of FP and CAC competencies to consist of both awareness and knowledge about the competencies *(9)*.

Development of a stakeholder dissemination plan

Step 2: Develop a dissemination plan

Engaging stakeholders is an important step in the dissemination process. A dissemination plan is essential to obtain buy-in from stakeholders at all levels for the adoption of the competencies to inform public health-related training and practice. It is necessary to have a stakeholder dissemination plan from the start of the promotion of CBE use. The process of identifying and engaging stakeholders provides an early opportunity to connect with relevant opinion-makers, influencers and decision-makers. Lessons from disseminating public health research findings emphasize that stakeholder engagement can be effective when the stakeholders are actively involved in the endeavour from the design onwards *(10)*.

Informed by assessment of the specific role that each stakeholder plays, their present awareness, knowledge of and willingness to engage with CBE for capacity development of the PHC workforce, the type of dissemination required for each of the stakeholders can be established. This can range from awareness-raising, when no clear understanding of CBE and the competencies for FP and CAC can be assumed, to knowledge-sharing when awareness is present but there is insufficient knowledge of the competencies and their use. Support can also focus on enhancing the willingness to implement the competencies in terms of adoption of a competency-based curriculum, inclusion of the competencies in pre- or in-service training courses or adaptation of regulatory health frameworks. Different kinds of stakeholders require tailored types of dissemination, resulting in advocacy adapted to the roles they play. **Instrument 2: Stakeholder dissemination plan** can be used to develop a dissemination plan. In situations where awareness, knowledge and willingness to implement are already present, the actual use of the competencies can be supported (see chapter "Implementation").

The various stakeholders, as identified in Table 1, will need to be specified for each specific national and subnational context in which the competencies are to be applied. Each of these stakeholders will play a specific role and their inclusion in the process is to be related to the part that they are expected to play. Stakeholder engagement can be considered at five levels: from simply informing a stakeholder (a one-directional dissemination process), consultation of a stakeholder (multiple-directional), involvement of and collaboration with a stakeholder (both often used for influencers), and stakeholder empowerment (usually used for decision-makers).

In summary, stakeholder assessment using Instrument 1 will inform the development of the dissemination plan using Instrument 2. The latter tool provides the opportunity to identify the dissemination objectives for each stakeholder, informed by the results of the assessment conducted using Instrument 1, and enables further specification of how you will engage with each stakeholder, including detailed key messages, communication channels, responsibilities and time frames. Thus, the objectives are linked to the existing levels of awareness, knowledge and willingness to implement of each stakeholder in the specific national and subnational contexts.

Key messages in the dissemination process may include a variety of issues.

- A conceptual introduction to CBE: For many stakeholders, the use of competencies as the means for learning and performance assessment may be a new concept. It will be important to explain what CBE is and how it differs from traditional training and learning approaches.
- An introduction to the FP and CAC toolkit, its menu of competencies and ways in which the competencies can be used in education, training and support of service delivery standards for quality FP and CAC services.
- Introduction to each of the individual competencies, tailored to the stakeholder concerned and adapted to their needs in terms of prioritization and/or selection of the competencies for use in a specific context.
- Introduction of the design model of FP and CAC competency development curriculum as outlined in volume 2 of the toolkit *(6)*.
- The interrelations between the competencies of individual health workers and organizational goals of health-care facilities and training institutions in the delivery of equitable and quality FP and CAC health services.
- Bringing together several partner organizations to synergize dissemination efforts and implementation of the competencies.

Different communication channels can be used to disseminate the competencies and ways in which they can be used. These include:

- making the content available in print and/or digital formats in the appropriate language;
- promoting dissemination via social media, websites and mailing lists;
- getting the publication endorsed and/or promoted by partner organizations;
- conducting in-person or virtual workshops tailored to specific audiences;
- building an online community of practice for those who are keen to participate, in order to share ideas, experiences, tools and applications, and provide feedback.

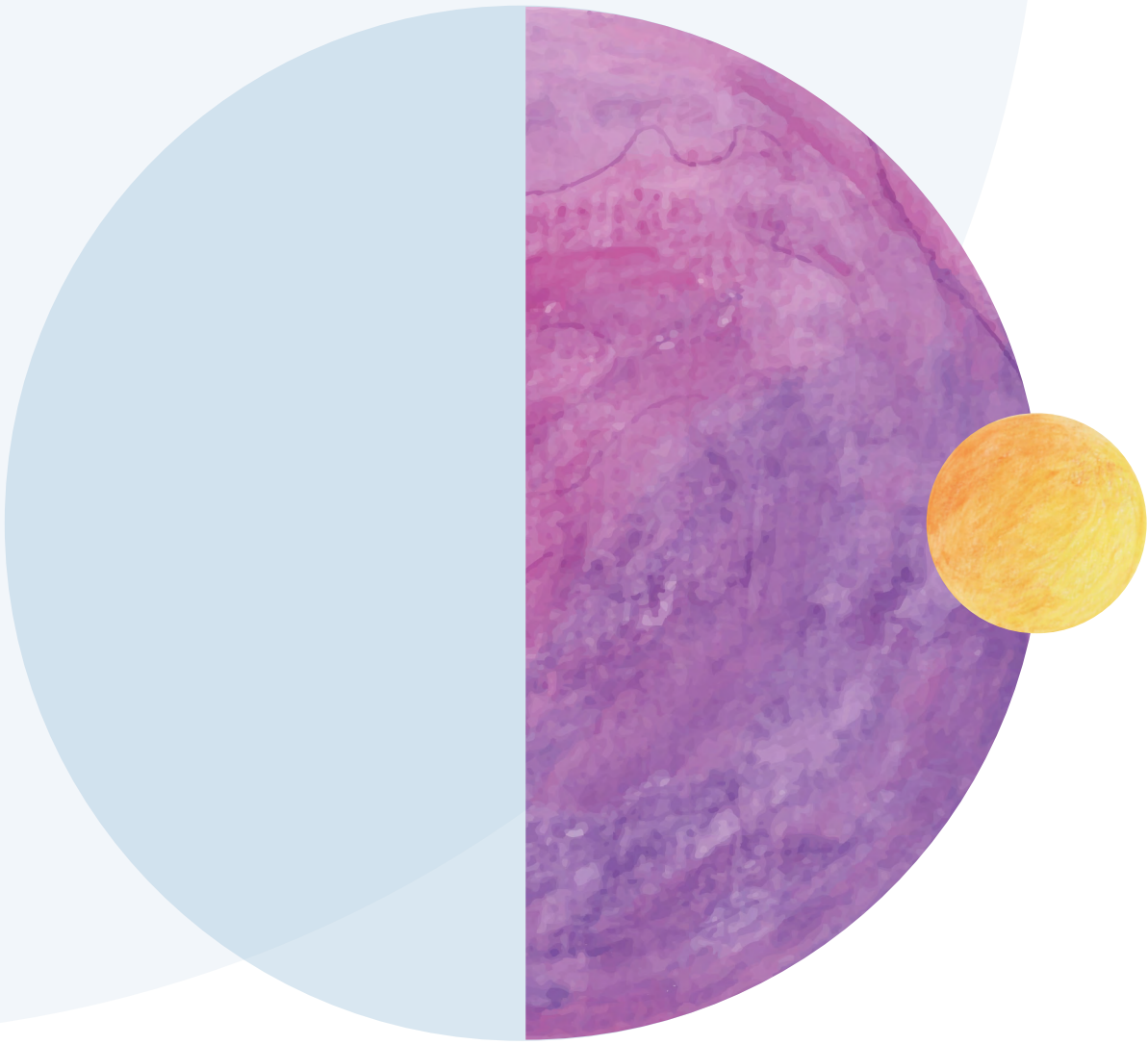
For each of the communication channels and messages identified with Instrument 2, responsibilities can be established. Finally, details of the time frame of activities will need to be provided. Messages disseminated through different channels need to be aligned with one another. For details of the use of different dissemination channels for different target groups see Table 3.

Table 3. Examples of dissemination channels for target groups

Target group	Dissemination channel examples
Professional associations	• Emails, websites • Podcasts (made as much as possible openly available) • Briefing flyers for communication teams • In-person presentations to key stakeholders
Civil society partners	• X (Twitter), Facebook or other popular social media platforms • LinkedIn for professional cadres • "Real life success stories" for gatekeepers and politicians • Policy briefs and issue briefs • Endorsement by local politicians
Educational organizations	• Inclusion in curricula of pre- and in-service health worker training • Inclusion of CBE in pedagogical training for educators • Inclusion in online courses including Massive open online courses on sexual and reproductive health and rights and other public health topics
Donors	• Inclusion in relevant corporate social responsibility initiatives • Inclusion in relevant grant proposals
Publications (especially scientific journals)	• Inclusion in editorial instructions to authors • Editorials on the topic to promote its visibility

It is important to take the following into consideration.

- Adapt messages to targeted recipients, including aspects of language and culture and other relevant aspects of national and local contexts.
- Adapt messages to the needs of the organizations concerned and the role(s) they play in FP and CAC competency development and service provision.
- Adapt the channel of communication to the preferences of the recipients.
- Apply strategies to address the needs and requirements of different stakeholders.
- Include personalized and interactive approaches to get your messages across.
- Apply time-efficient ways of communication.
- Conduct in-person dissemination whenever possible with policy-makers *(11,12)*.
- Ensure human and financial resources are in place to conduct dissemination activities.

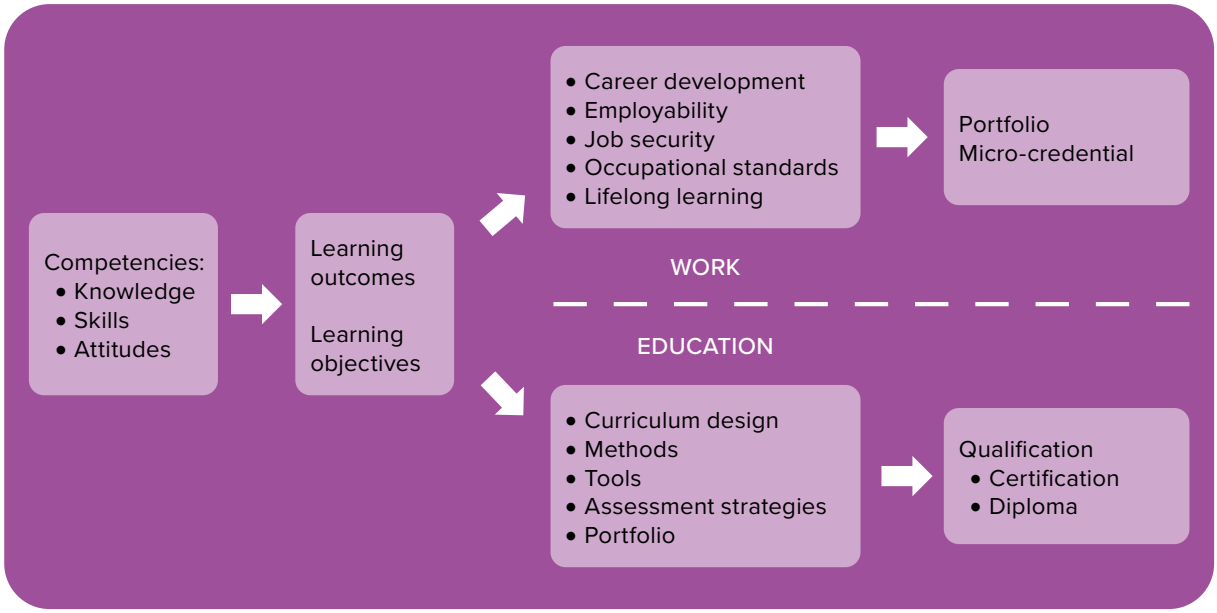


Implementation

Implementation in work and education settings

The FP and CAC competencies can be used by a variety of stakeholders in a diversity of settings. One main distinction concerns use of the competencies in health-related work settings versus health-related education settings. This is important as each setting requires different considerations. For details see Figure 3.

Figure 3. Competency development for both education and work settings



In health-related work settings, the competencies can be used to inform aspects of career development and performance appraisal, set standards for recruitment, enhance job security, set occupational standards, provide details for job descriptions and requirements, and as a part of lifelong learning. In a work setting, the competencies can also be useful in labour market analysis and career guidance.

In health-related education settings, on the other hand, the focus will be on inclusion of the competencies in the existing curricula for health professionals – including doctors, midwives, nurses, community health workers and pharmacy professionals – and adapting methods and tools to enable an explicit focus on skills development (in addition to a focus on knowledge and attitudes). The competencies can be used to identify training needs, identify related objectives for training and qualifications, and inform the design of learning activities. Changes in curricula, teaching and training methods that are informed by the FP and CAC toolkit for the PHC workforce will need to be reflected in the assessment of learners and in certification and diploma criteria.

The competencies, moreover, provide a shared language for attitudes, knowledge and skills required for high-quality FP and CAC service provision, which can facilitate collaboration across various types of health worker cadres and between health and education professionals, and can thus enable work in multidisciplinary teams, role optimization and interorganizational collaboration.

In this chapter, to facilitate the use of the competencies, we look at assessment of the needs of the health-related user organization and provide a step-wise process for the development of an implementation strategy.

Development of an implementation strategy

As with the dissemination plan, several steps are required in the development of an implementation strategy, including assessments to inform the actual preparation of the strategy. An FP and CAC strategy can be developed at several levels, including national, subnational health administration and facility levels. Strategies at higher levels of implementation require more extensive assessments to underpin them.

Step 3: Assessment of capacities of the user organization(s)

The use of the FP and CAC toolkit and implementation of the competencies need to be informed by an assessment of the capacity of any organization that aspires to implement the competencies. Such user organizations can include employment, education, regulation and other government-related agencies, health-care facilities, multilateral organizations and NGOs. The assessment makes use of **Instrument 3: Capacity assessment of user organizations**.

Step 4: Assess key attributes that can enhance successful adoption

Some key stakeholder attributes can enhance the successful adoption of the competencies by the stakeholders concerned. If there is a clear recognized need for the use of the competencies for example, or when they are considered a credible innovation, then the competencies may be more easily accepted. Table 4 illustrates attributes that should be reflected upon when developing an implementation strategy. The competencies are more likely to be effectively adopted if the stakeholder meets most of these attributes *(13)*. The responses to the questions will depend on the purpose of adopting the competencies and the context in which they will be used. An overview of attributes is presented, with possible answers to the key questions. However, in each specific context of application of the competencies, these issues need to be established within the specific setting concerned and ways to address any constraints identified. **Instrument 4: Attributes for implementation of the competencies, key questions and identification of follow-up** can be used for this assessment.

Table 4. Attributes for implementation of the competencies and key questions with generic answers

	Attribute	Key question(s)	Possible answers
1	Credibility	Is there evidence that the FP and CAC competencies and their use are a credible innovation?	Competency-based learning and practice are currently the preferred model in health care. Evidence shows that competencies can clarify critical skills, knowledge and behaviours; standardize and ensure comparable outcomes of medical curricula; and ensure graduates are ready to serve their communities *(2–4)*.
2	Observability	Will the results of use of the competencies be observable/ measurable?	The right methods for M&E need to be implemented from before commencement and after use in order to identify the resulting changes.
3	Relevance	Will use of the competencies address a persistent need or problem?	A PHC workforce that is well trained and prepared to provide high-quality care has the potential to enhance access to care and reduce health disparities *(14)*. Successful use of competencies brings benefits by aligning organizational goals and individual performance, preventing patient harm while improving clinical outcomes.
4	Relative advantage	Will the use of FP and CAC competencies bring advantages, including cost–effectiveness?	Introducing competencies for health worker development contributes to cost-effective human resource management *(15)*. Competency-based approaches ensure that health workers are better equipped to achieve optimal performance outcomes.
5	Ease of transfer/ installation	Are the competencies easy to understand and operationalize?	In selected cases, there was great optimism around the effort to standardize competencies for medical practitioners and revise the curriculum. Local staff recognized the need for simple, innovative processes to reform existing curricula, competencies and licensing systems *(16)*.
6	Compatibility	Will use of the competencies be compatible with existing policies and systems? To what extent will adaptation be required?	Adaptation of the competencies involves prioritization of competencies based on identified capacity gaps and needs and, if required, adapting language to national and local contexts rather than adapting the competencies. Use of the competencies might trigger review/adaptation of the medical/residency programme to ensure compatibility.
7	Testability	Can the success of the implementation be tested at different stages of implementation?	Implementation of the FP and CAC competencies by a user organization can be organized in an incremental way and assessed in stages with use of an M&E framework to monitor results and inform their optimization *(17,18)*.

CAC, comprehensive abortion care; FP, family planning; M&E, monitoring and evaluation; PHC, primary health care.

Source: Adapted from Glaser, 1983 *(13)*.

Step 5: Assess the external environment and identify enabling and constraining external factors to successful adoption of the competencies

The implementation of the competencies in both work and education settings does not take place in a vacuum, but within a wider context in which there may be conditions and institutions (external to the health practitioners and educators) that influence the opportunities for application of the competencies.

In situations in which awareness, knowledge and willingness to implement the competencies are present in the user organization (along with other organizational requirements), focus needs to be on any external constraints that may block the use of the competencies.

Instrument 5: Assessment of public enablers for and constraints to implementation of the competencies can be used to identify "public enablers" to inform the implementation strategy.

Step 6: Develop the implementation strategy, tailored to the needs, capacities and external context of the organization targeted

Develop an implementation strategy for the organization concerned that is informed by the assessments of the user organization (including its capacities and needs), the key attributes for implementation of the competencies, and the enabling and constraining factors of the external environment. The strategy needs to be specific, tailored to the organization in the education or work-related health field. It identifies priorities, partner organizations, and those agencies that will support the process in technical and/or financial ways. **Instrument 6: Contents of the implementation strategy document** can be used to develop an implementation strategy.

If required, develop an overarching country-wide strategy

At country level, the strategies for the adoption of the competencies by multiple organizations can be pulled together into an overarching strategy, which includes shared components across the organizations as well as organization-specific issues and concerns. Such a strategy may be useful to enhance coordination across organizations, enable synergies and reduce costs. This bottom-up approach will be particularly important for use in countries where parts of the health system are decentralized and important decisions, including resource allocation, are made at the subnational level.

Conversely, in certain situations one may want to start from a national level and develop a generic implementation strategy, which is then tailored to the specific needs of each of the participating organizations. This may be relevant for countries where the health system is highly centralized.

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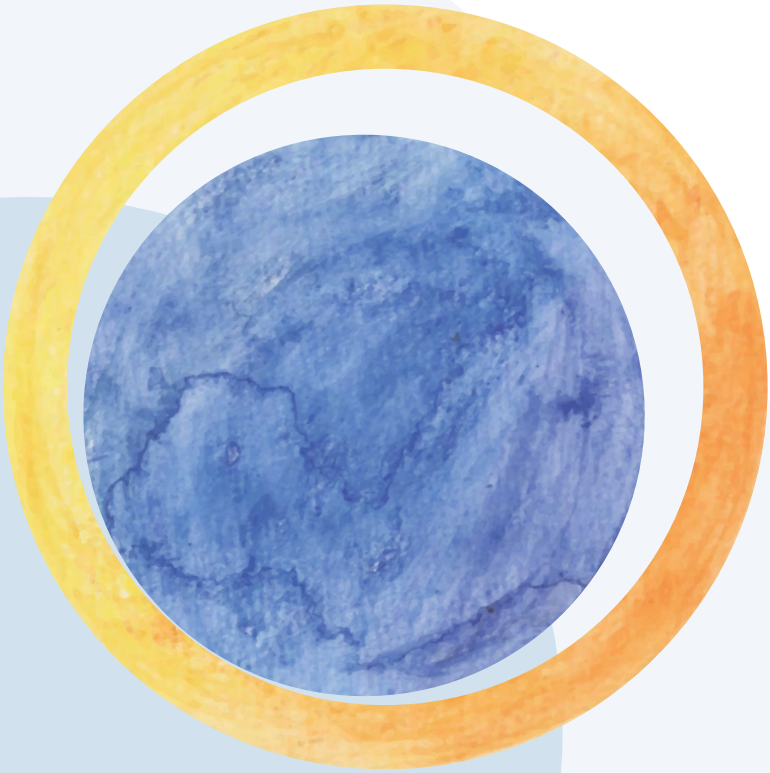


Monitoring and evaluation

Why monitor and evaluate?

Monitoring and evaluation (M&E) have been increasingly recognized as important means of accountability and learning that can be applied at multiple levels – in this instance for assessment of results in relation to the use of the FP and CAC competencies. The use of M&E will enable the assessment of what works and what does not in specific settings in terms of the implementation of the competencies and through documentation of such experiences and lessons learned. This then informs adoption, use and possible future adaptations of the competencies.

Monitoring is the routine tracking of a programme's activities by regularly assessing whether or not planned activities have been implemented, resources used, and results reached. Evaluation is a process of systematically determining the relevance, effectiveness, impact, efficiency, coherence and sustainability of interventions in relation to their design and actual programme implementation. Evaluation uses monitoring data to assess the meaning of changes assessed *(19)*.

M&E can be conducted for a variety of levels and initiatives. As seen in Volume 2 *(6)*, it can be used to assess the development of the curriculum and its implementation, including assessment of course and programme structure, faculty performance and learner outcomes. It can also be performed at the level of competency development of a national or subnational initiative or at the level of selected health-care facilities whose staff have been included in training on the competencies – assessing the effects in terms of their performance as health-care providers in delivery of FP and CAC services.

With CBE being outcome-based, as made explicit in the definition used by WHO, there are clear opportunities for M&E to assess the results of such education initiatives. It is important to keep in mind that the complexity of the M&E effort needs to be proportionate to the complexity of the initiative concerned. When, for example, most of the staff of a certain facility are trained in the application of the competencies, one might be able to show results at the facility level, which would not be the case if just a few staff were involved in the training. Examples of the benefits of conducting M&E of a variety of initiatives are presented in Table 5.

Table 5. Examples of benefits of conducting M&E of a variety of initiatives

	Kind of initiative	Examples of benefits of conducting M&E
1	Training of individuals	Participants receive feedback on the level of knowledge gained, which can be used to further fine-tune the training programme
2	Training of most of the staff of an obstetrics and gynaecology department	Assessment of the changes in attitudes and behaviour of the trainees in their work can identify results of the training and detect other constraints to practising the competencies
3	Training for faculty of nursing training institutes	Assessment of the knowledge gained through the training and the application by the faculty staff in their training of primary health care workers can inform the training of the faculty and show how the competencies have been incorporated into the faculty training programme
4	Development of a training curriculum for a specific programme in a selected country	Assessment of the process of the development of the curriculum and its results can highlight the benefits and limitations of the curriculum, and highlight aspects and processes for improvement in the context of the country concerned
5	Competency-based training institutionalized through policies and plans	Assessment of the initial implementation of the policies and plans in the specific country context can inform future implementation and can identify gaps that need to be addressed

At what level is it suitable to conduct M&E?

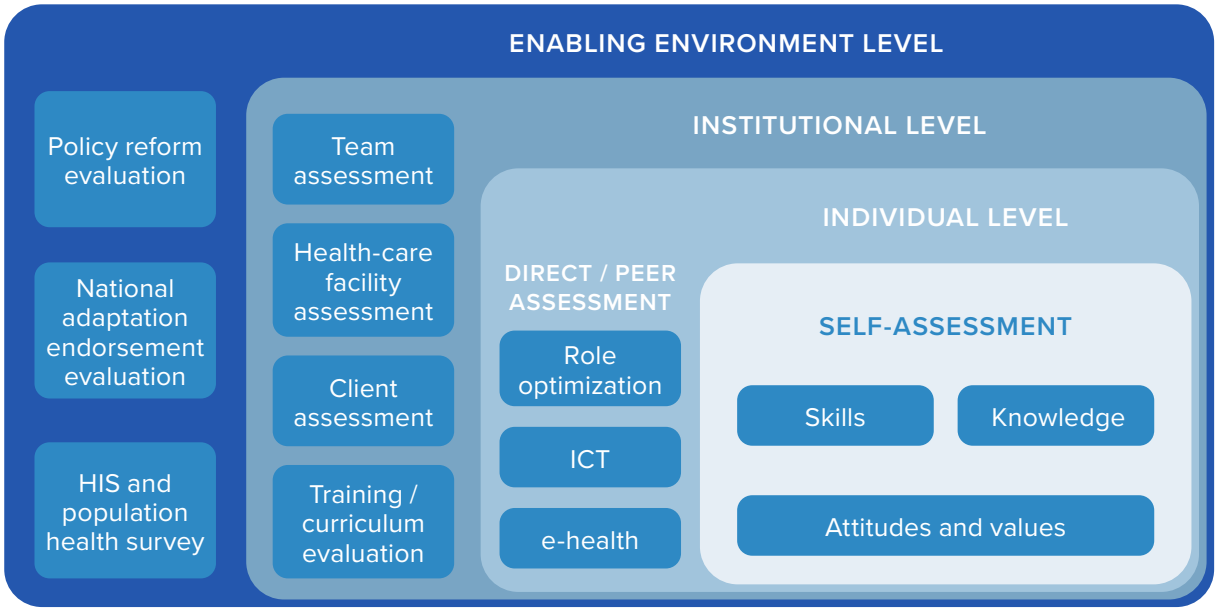
As the FP and CAC competencies can be used by a variety of stakeholders at individual, institutional and enabling-environment levels, M&E can take place at each of these levels. Details at the individual level concern aspects of knowledge, skills and practice development, while assessment can also be conducted on the curriculum and course syllabus. Both these types of assessment are included in Volume 2 of the FP and CAC toolkit *(6)*.

At the institutional level, including health-care facilities, health educators and regulators, and the organizations in which they function, M&E assesses their knowledge and use of the competencies in their work, including in pre- and in-service training and in regulatory practices.

At this institutional level, multilateral health-related agencies – such as WHO and the United Nations Population Fund (UNFPA), professional organizations (including midwifery, obstetrics and gynaecology, medical and nursing associations), health-related civil society organizations and country-specific reproductive health-related organizations – are active in terms of possible support to and use of the competencies in the design and implementation of their initiatives at national and subnational levels to enhance delivery of high-quality FP and CAC services. M&E can be used by these organizations to assess the results of initiatives using the competencies.

At the third level, the enabling environment, stakeholders include ministries of health and education. This level includes the legal and policy frameworks and development plans in place that can enable the use of the competencies and enhance their application by training institutes and all levels of health-care facilities. (For details see Fig. 4 and Table 6.)

Figure 4. Levels at which M&E assessment of competency-related initiatives can be conducted



HIS, health information system; ICT, information and communications technology.

Source: Adapted from EC, 2018 *(20)*.

Selection of the level at which to conduct M&E depends on what kinds of initiatives have been undertaken within a country at national or subnational levels to introduce the competencies and make use of them in pre-service and in-service training and other types of health worker capacity development and/or to support the enabling environment concerned.

Table 6. Aspects of assessment and evaluation at enabling-environment, institutional and individual levels

What is assessed and evaluated?	Who is involved?	What is analysed?	Methods/tools
All three levels combined: enabling-environment, institutional and individual			
Results of substantial support provided at multiple levels	All stakeholders combined	Impact of the use of the competencies on quality of FP and CAC services	Client sample survey; household sample survey
Enabling-environment level			
National enabling environment for the implementation of the competencies, for both health-related education and work settings, in order to promote the use of the competencies and improve FP and CAC practices	Policy-makers including ministries of health and education; health service managers; national health regulatory bodies	Data related to policy reform and national adaptation of the competencies; monitoring of the national roll-out of the use of the competencies	Qualitative analysis, policy analysis, timeline analysis

What is assessed and evaluated?	Who is involved?	What is analysed?	Methods/tools
Institutional level (health-care facilities, academic/training establishments)			
The extent of competency-based curricula development and use in pre- and in-service settings; what proportion of the workforce in health-care facilities demonstrates performance of the competencies?	Educationalists, faculties, colleges, training institutions, health learning institutions, planners, health service managers, service organizations, health programme implementers, academic/training establishments, clinical placement providers, occupational and professional associations, subject managers, experts	Data and information at the institution level, which can feed into national data-gathering systems and can include feedback from education institutions and health-care facilities on the use of the competencies Data on health-care facility assessments, administrative records of professional registries, records of health education and training institutes, and qualitative studies	Skills gap analysis to understand the availability of the competencies in the facilities Direct observation of facilities to assess existence of skills lab, electronic logbooks and other means for use in competency-based education
Individual / learner level			
Individual-level learning (knows; knows how; shows how; does – see Vol. 2 *[6]*) To what extent individual performance of competencies in practice settings and achievement of professional development learning objectives meet the necessary proficiency levels	Learners and prospective learners, including those doing internships and residencies; health workers, educators; public and private employers; user groups (patients, community groups, minority or marginalized groups)	These data can include individual performance against national standards and curriculum objectives, or quality-of-care standards in health-care facilities Individual assessments can also provide informative feedback to learners/health workers on progress, or feedback to educators/coaches on the success of different learning approaches and from the perspective of different user groups	Reflective diaries, logbooks 360-feedbacks, progressive evaluations e-portfolios (For details on individual learning assessment see Vol. 2 *[6]*; on e-portfolios see Vol. 4 *[21]*)

Planning for M&E

Step 7: Development of the M&E plan

As with any health-related intervention, M&E of support to the development of FP and CAC competencies requires an M&E plan from the outset of the initiative. This enables monitoring to start from the beginning of the intervention and collection of baseline data, to which results obtained at a later stage in the project cycle can be compared. Also, in terms of assessment of results at individual health practitioner level, data of a non-target group could be collected at the start of the intervention, to enable before-and-after comparisons between targeted and

non-targeted health practitioners. Such a comparison would provide a stronger evidence base, particularly useful for pilot interventions that are expected to be scaled up and which would benefit from evidence-based advocacy.

In addition to a results framework, the M&E plan requires a monitoring plan, details on data management, an evaluation plan, reporting arrangements, details on roles and responsibilities of the people/organizations involved, building of M&E capacities and budgetary details (see Table 7 for details). Note that for a more complex initiative an extended M&E plan will be required, while for a modest initiative a basic version of the plan would be sufficient. **Instrument 7: Contents of the M&E plan** can be used to develop the M&E plan.

Table 7. Details of the monitoring and evaluation plan

	Item	Description
		Basics
1	Introduction	Relevant details of the design of the initiative concerned, including geographic scope and time frame
2	Results framework	Outline of the inputs, outputs, outcomes and impact of the initiative in a framework that shows the causal relationships between these levels of results, and indicators meant to assess success at each level
3	Monitoring plan	Plan that outlines the collection of data on indicators of progress of the initiative, including details of the means of verification of the indicators of the results framework and frequency of data collection
4	Evaluation plan	Plan for the intermittent, mid-term and end-of-initiative evaluations of the intervention, including the use of evaluation criteria of relevance, effectiveness, impact, efficiency, sustainability, coherence and others deemed relevant in the context concerned – including the identification of baseline data and details on the evaluation methodology, using mixed methods in terms of data gathering and analysis
5	Roles and responsibilities	Roles and responsibilities of M&E and other staff of the organization and initiative concerned, partner staff (in terms of the implementation of the M&E plan), amount of time to be dedicated and supervision arrangements
6	Budget	Budget for M&E activities throughout the implementation of the initiative, including monitoring, evaluation and reporting activities and M&E capacity development
		Additional Items
7	Data management and analysis	Details of how data are being stored, managed and cleaned, and how they are being analysed
8	Reporting arrangements	Ways in which monitoring and evaluation and other relevant project data are being reported, how frequently and who will receive the data and reports
9	Building of M&E capacities	Development of capacities in M&E during the implementation of the initiative, along with guidelines and other documentation to be used by staff engaged in the implementation of the M&E plan

M&E, monitoring and evaluation.

Step 8: Development of the results framework

In the results framework, the expected results of the initiative are outlined along with indicators to assess success and the ways in which targets will be verified, and the kind(s) of data required. Output-, outcome- and impact-level results within the framework are causally linked, and assumptions and risks related to these linkages identified. Inputs are the human, financial and other resources required for the implementation of the initiative. The results framework guides the assessment of achievement of results. **Instrument 8: Components of the results framework** can be used to develop the results framework.

M&E methods and tools

A variety of qualitative and quantitative methods and tools are available for data collection and analysis in the assessment of results achieved and other evaluation criteria.

Quantitative versus qualitative methods of data collection *(22)*

- **Quantitative methods:** Evaluation methods that rely on categorical or numerical data. Evaluation based on quantitative data is primarily deductive, in that it begins with a hypothesis and uses the data to make specific conclusions. Quantitative methods include assessments and tests, surveys and questionnaires, and some types of secondary data collection.
- **Qualitative methods:** Evaluation methods that rely on non-categorical data and free response, observational or narrative descriptions. Evaluation using qualitative methods is primarily inductive in that data are collected and examined for patterns. Qualitative methods include interviews and focus groups, observations, case studies and some types of secondary data collection.

To build a credible evidence base, both types of data collections and analysis are usually required in a mixed methods set-up, with each approach having a range of tools available.[3]

An important way of assessing results is to use indicators, with specification of baseline data and targets to be achieved through a programmatic intervention. An indicator is described as a:

> *quantitative or qualitative factor or variable that provides a simple and reliable means to measure achievement, to reflect the changes connected to an intervention, or to help assess the performance of a development actor (23).*

3. The Rainbow Framework of Better Evaluation, provides a range of different methods and processes that can be used for each task in M&E: www.betterevaluation.org/frameworks-guides/rainbow-framework.

Good practice when defining indicators includes that the indicators should be "SMART":

- **Specific:** measures only the specified result
- **Measurable:** so that the result can be compared and tracked over time
- **Attainable:** so that the result can be compared against a realistic target
- **Relevant:** to the intended result
- **Timebound:** related to a specific time period *(24,25)*.

Other good practice aspects of indicators include:

- limited in number and thus feasible in terms of effort required for their assessment and analysis;
- inclusion of qualitative indicators and analysis of qualitative aspects of quantitative indicators (qualitative data providing depth to quantitative findings);
- adapted to the national and subnational context concerned;
- developed in partnership with relevant stakeholders to ensure a common understanding of what success looks like and how it can be assessed.

Table 8 provides illustrative indicators that could be used to assess the degree of success reached through operationalizing the FP and CAC competencies at enabling-environment, institutional and individual levels. While the indicators of the enabling environment are assessed at national level and can be aggregated at (sub)regional and global levels, those at institutional level are assessed at the level of the institutions concerned and can be aggregated at subnational and national levels. Individual-level indicators are assessed at the level of individuals and can be aggregated at institutional, subnational and country levels. These examples are not exhaustive, or absolute.

Table 8. Examples of indicators at enabling-environment, institutional and individual levels

Level	Indicator	Target	Means of verification	Frequency of assessment
		Enabling-environment level		
Outcome	Accreditation mechanisms for education and training institutions regarding competencies in place	Yes	National-level review	Annually
	Competency-based training on FP and CAC included in the national health plan and its monitoring system	Yes	National health development plan review	Once plan released
	Number of countries at global or (sub)regional level with health sector policies that base career advancement and promotion on merit and capacity, including staff competencies, rather than seniority	Increasing number of countries over time	Health sector policies at national level	Once every two years

Level	Indicator	Target	Means of verification	Frequency of assessment
Output	Number/type of policy documents institutionalizing the SRHR competency-based education and practice	Number/type of policies agreed	Government reports	Quarterly
	Percentage of conducted versus planned dissemination sessions (training activities, webinars, workshops)	100%	Institutions' reports	Quarterly
Input	FP and CAC competencies for PHC scale-up budget meets national average for similar scale-up interventions	100%	Government reports	Annually
	Institutional level			
Outcome	Percentage of health-care facilities conducting FP and CAC competency-based training and assessment of students (internships, residency) and qualified personnel	Year 1: 10% Year 5: 50% Year 10: 80%	HIS, desk review	Annually
	Percentage of public and private education institutions adopting SRHR competency-based curricula on FP and CAC in teaching and assessment	Year 1: 10% Year 5: 50% Year 10: 100%	Private and public sector data, national surveys	Annually
	Percentage of health-care facilities including the FP and CAC competencies in the requirements for job descriptions and recruitment processes for SRHR-related staff positions	Year 1: 10% Year 5: 50% Year 10: 80%	HIS, desk review	Annually
Output	Percentage of trainers in education/ training institutes trained on FP and CAC competency-based education and assessment	Year 1: 10% Year 5: 50% Year 10: 80%	HIS, desk review	Annually
	Percentage of senior health staff trained on FP and CAC competency-based education and assessment	Year 1: 10% Year 5: 50% Year 10: 80%	HIS, desk review	Annually

Level	Indicator	Target	Means of verification	Frequency of assessment
		Individual level		
Impact	Percentage of SRHR clients of reproductive age satisfied with the quality of FP and CAC health-care facility services	100%	Qualitative client exit survey	Annually
Outcome	Percentage of health workers fully competent in providing FP and CAC services in the health-care facility	100%	Health-care facility records, HIS	Annually
	Percentage of SRHR competency-based certified students graduated and entered the workforce	100%	HIS, national health workforce accounts, government reports; reports from education institutes	Annually
Output	Number of students graduated from FP and CAC competency training	Targets of training institutes	Records of training institutes	Annually

CAC, comprehensive abortion care; FP, family planning; HIS, health information system; PHC, primary health care; SRHR, sexual and reproductive health and rights.

In addition to gathering and analysing quantitative primary data through indicators, there is also a need to include qualitative data and analysis as part of a mixed methods approach to M&E. This can be achieved through the inclusion of qualitative indicators and milestones in the results framework of a programme or project. However, more comprehensive qualitative data collection methods exist. Some of these methods, used in international development programming, are presented below.[4]

Use of qualitative methods for primary data collection and analysis

Key informant interviews

These are qualitative, in-depth interviews of a range of people selected for their first-hand knowledge about a topic of interest. The interviews are structured using a list of topics for discussion. Key informant interviews allow for a free flow of ideas and information. Key informants, with their particular knowledge and understanding, can provide insight on the nature of problems and issues, and provide recommendations on ways to address problems and on possible future interventions *(26)*. Key informant interviews are most relevant to collect data in relation with instruments 1–5.

4. Though some of these methods also include aspects of quantitative data collection, the focus here is on their use as methods of qualitative data collection and analysis.

Focus group discussions

A focus group discussion is a method for collecting qualitative data that gathers a group of peer individuals together to discuss a specific topic. Questions are open-ended with the aim of stimulating an informal discussion to understand participants' perceptions, beliefs, fears, questions and information needs in relation to the topic concerned. To ensure collection of the viewpoints of all relevant stakeholders and in particular those of vulnerable and marginalized groups, it is best practice to conduct, whenever relevant, separate focus groups with men and women, and with particularly vulnerable groups *(27)*. Focus group discussions can be used with instruments 1–5.

Outcome mapping

Outcome mapping is used to assess the intermediate changes that need to be attained to reach an organization's vision. Outcome mapping focuses on capacities of partner organizations through assessment of changes in the behaviour, relationships and activities of the parties with which a programme works directly. Development is seen as accomplished through changes in behaviour of people and organizations, which is therefore central to the methodology. Through application of a participatory approach, outcome mapping builds the monitoring capacity of partner organizations using a learning perspective *(28,29)*. Outcome mapping is most relevant for use with instruments 3 and 5.

Process monitoring and documentation

This method concerns assessment of the process of change, focused on qualitative aspects, enabling analysis of the process through which change is achieved and subsequently informing the process itself and its results. This method addresses how results were achieved rather than focusing on the results themselves. This is of particular importance in pilot and other innovative initiatives, and in more open-ended programme approaches, in which there is a need for incremental learning and to document such processes for future programme initiatives *(30)*. Process monitoring is most relevant for use with instruments 1–5 in terms of assessing changes occurring over time.

Most significant change tool

This methodology aims to assess and interpret changes that have occurred in a certain target group or area and to develop a dialogue on the values attached to these changes by key stakeholders. It makes use of "domains of change" to guide the process of gathering stories of change. The approach asks participants to tell their story about "the most significant change" in a certain period regarding the domain of change selected. Participants analyse the results through a step-wise process of selection of the most significant change stories, ending up with one story that represents the most significant change. The stories of change are holistic and consider multiple aspects of change. Through its open-ended approach, this method enables identification of unexpected and unplanned change *(31,32)*. This tool is most relevant for open-ended assessment of results achieved over long periods of time, including assessment of unexpected and unwanted changes.

Learning

Step 9: Learning during the process of implementation

In addition to enabling accountability in the use of resources, M&E provide important means for learning throughout the implementation process of the competencies. Learning is important as it can enhance the ways in which the competencies are taught and applied, and result in enhanced quality of FP and CAC services provided. Through the gathering and analysis of quantitative and qualitative data and information, M&E provide important opportunities to assess what works and what does not and why. Using such insights can increase results achieved through the use of CBE. While evaluation provides an important external perspective, there is the opportunity to conduct intermittent internal review and analysis and generate lessons, which in turn can inform evaluation by independent specialists.

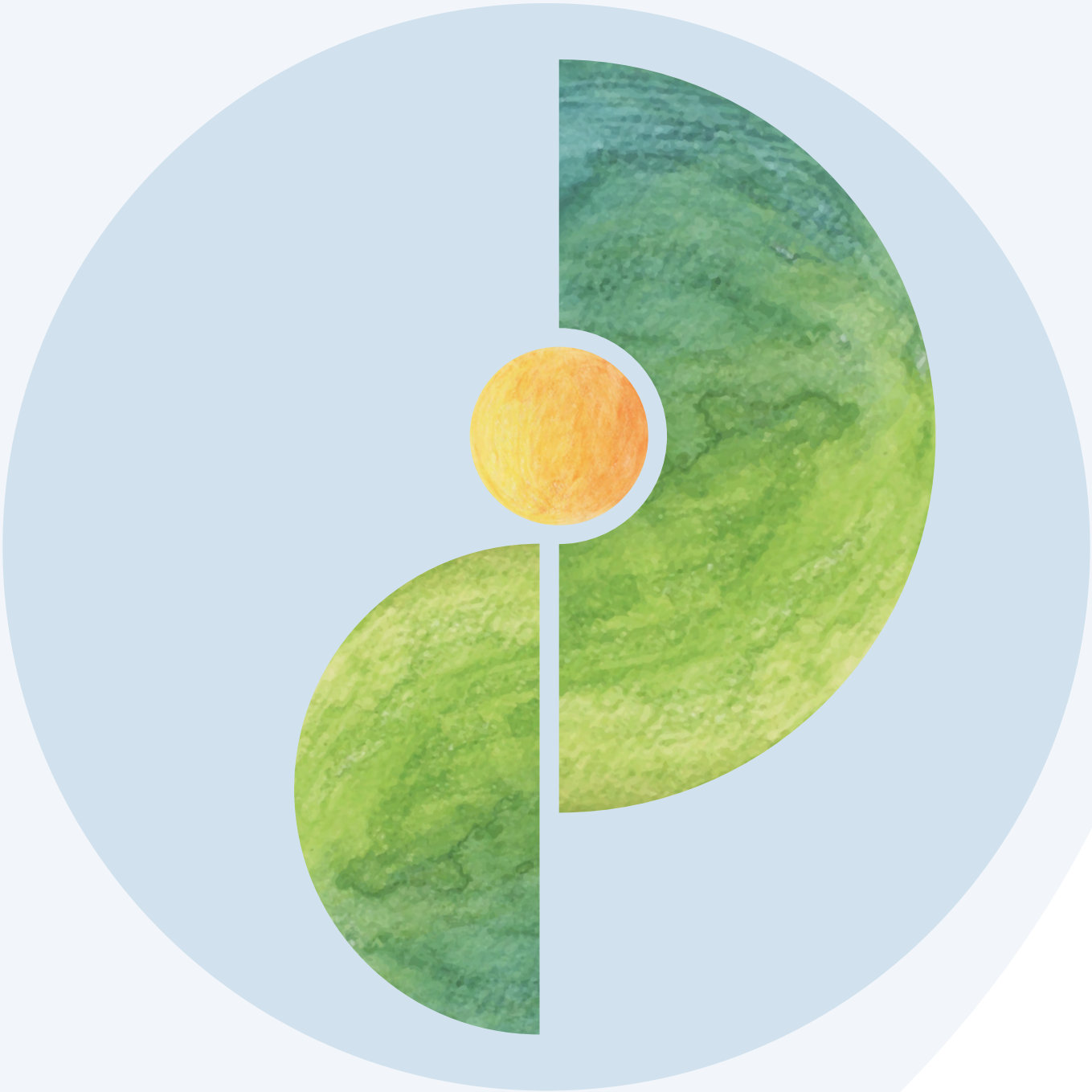
In addition to learning at the level of projects and initiatives, learning also takes place at the individual level. For this type of learning, electronic portfolios are an important means to support the learning process and its results. A portfolio is a type of learning record that provides actual evidence of achievement. A portfolio facilitates a student's reflection on their own learning, leading to more awareness of learning strategies and needs. This applies to pre-service, in-service and informal on-the-job and life-long learning. E-portfolios are electronic versions of portfolios with details of their use presented in Volume 4 of the FP and CAC toolkit for the PHC workforce *(21)*.

Learning sessions

Learning from experiences in the use of the FP and CAC competencies can be achieved at multiple levels. Lessons learned can be identified at the level of health-care facilities, health departments and ministries, health-supporting civil society organizations and United Nations organizations, health-related educational facilities and other stakeholders involved in public health promotion. To facilitate such learning, **Instrument 9: Learning tool on the expansion of use of the FP and CAC competencies** focuses on the expansion of the use of the competencies in multiple contexts informed by learning.

Learning strategy

WHO has developed its public health learning strategy *(33)*, the goal of which is to shape the future of learning in public health to support the achievement of international, national, institutional and individual public health goals – ensuring equity and access, harnessing the potential of digital and other technologies, and using adult learning and behavioural change know-how. National ministries of health, subnational departments of health, health-care facilities, civil society and other supporters of public health can feed into this strategy with their own lessons learned and experiences. It will be important for the further implementation of the FP and CAC competencies to identify such a strategy as part of the wider public health learning strategy, to inform the process of implementation of the competencies with experiences and learning gained through the implementation process.



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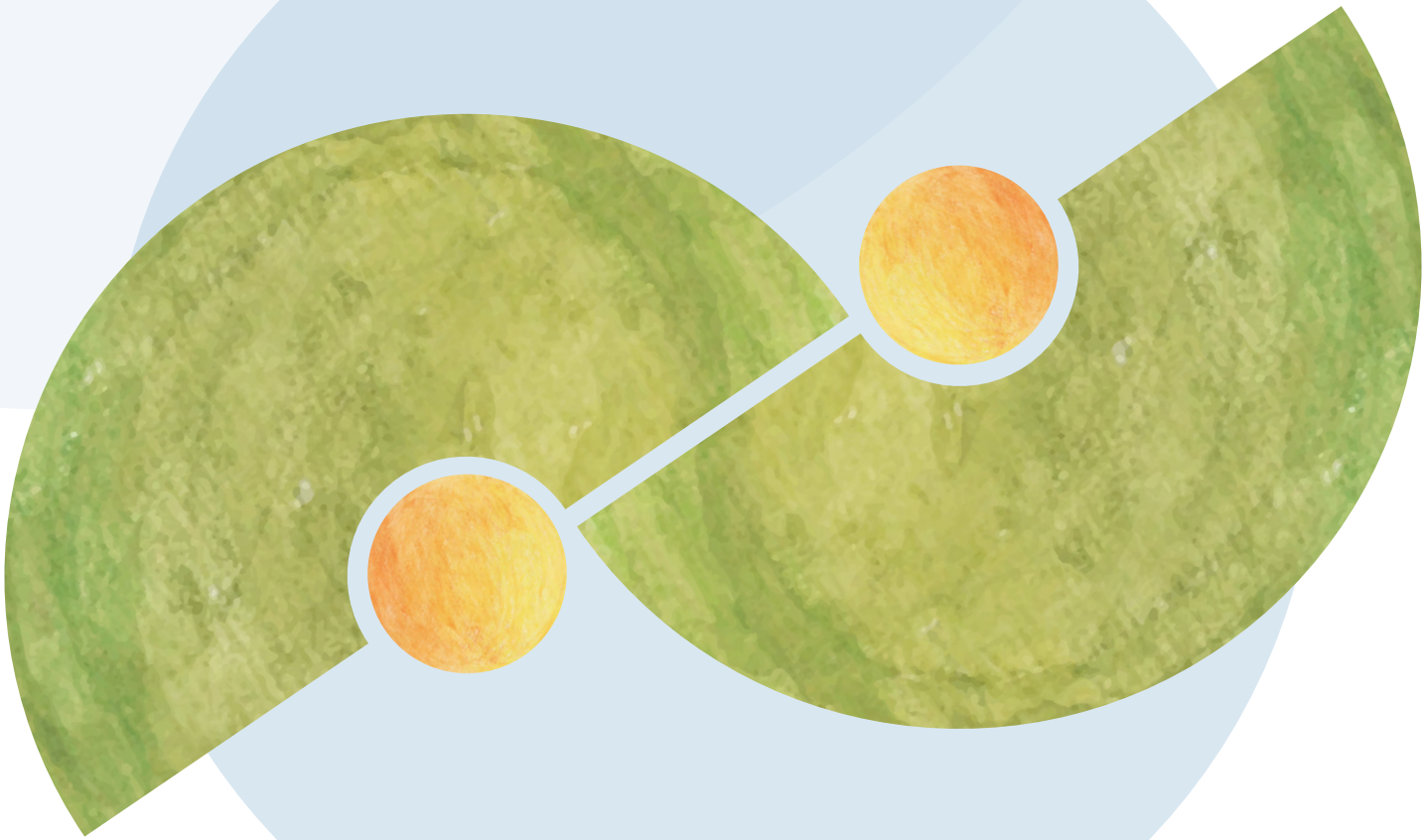

Annex

Instruments

Contents

Instrument 1

Assessment of level of engagement of each of the stakeholders with the FP and CAC competencies

Assess for each of the relevant stakeholders the role that they play in competency-based education (CBE) of the family planning (FP) and comprehensive abortion care (CAC) competencies and their present level of engagement in terms of awareness, knowledge and willingness to implement the competencies.

	Role(s) in FP/CAC CBE	Awareness of FP/CAC competencies	Knowledge of FP/CAC competencies	Willingness to implement FP/CAC competencies
Stakeholder 1				
Stakeholder 2				
Stakeholder 3				
Stakeholder 4				
Stakeholder ...				

Instrument 2

Stakeholder dissemination plan

Provide for each of the stakeholders details regarding the dissemination of the FP and CAC competencies, making use of information gathered through the use of Instrument 1.

	Dissemination objectives	Key messages	Communication channels	Responsibilities for dissemination	Time frame
Stakeholder 1					
Stakeholder 2					
Stakeholder 3					
Stakeholder 4					
Stakeholder ...					

Instrument 3

Capacity assessment of user organizations

Provide details for each key stakeholder, building on the assessment through the use of Instrument 1, regarding their capacities for the implementation of the FP and CAC competencies.

	Issue	Description
1	The rationale for the use of the competencies within the organization and identification of the organization's need	
2	Commitment of the leadership of the organization to the use of the competencies	
3	Commitment of the staff of the organization to the use of the competencies	
4	Identification of internal "champions" for use of the competencies, who can be considered as advocates within the organization	
5	Identification of any internal "opponents" to the use of the competencies, who will need to be convinced to get on board with the process	
6	Allocation of human and financial resources to enhancing competency-based education and establishing a competent FP and CAC PHC workforce	
7	Identification of other enabling or constraining factors for use of the competencies by the organization, including timing and organizational context	

CAC: comprehensive abortion care; FP: family planning; PHC: primary health care.

Instrument 4

Attributes for implementation of the competencies, key questions and identification of follow-up

Provide answers to each of the key questions regarding the seven attributes concerning implementation of the competencies in the context concerned and provide follow-up required to address identified limitations and/or constraints.

	Attribute	Key question(s)	Answer	Follow-up required
1	Credibility	Is there evidence that the FP and CAC competencies and their use are a credible innovation?		
2	Observability	Will results of the use of the competencies be observable?		
3	Relevance	Will use of the competencies address a persistent need or problem?		
4	Relative advantage	Will the FP and CAC competencies bring advantages, including cost–effectiveness?		
5	Ease of transfer/ installation	Are the competencies easy to understand and operationalize?		
6	Compatibility	Will use of the competencies be compatible with existing policies and systems? To what extent is adaptation required?		
7	Testability	Can the success of the implementation be tested at different stages of implementation?		

Instrument 5

Assessment of public enablers for and constraints to implementation of the competencies

Provide findings of the assessment of public levers and constraints present for the implementation of the competencies in the context concerned.

	Issue	Description
1	Political commitment and leadership outside the user organization concerned	
2	Conduciveness of governance and policy frameworks	
3	Outside funding	
4	Outside support for the adoption of the competencies by the user organization and leverage of outside support	
5	Outside resistance to the adoption of the competencies by the user organization and leverage of outside resistance	

Instrument 6

Contents of the implementation strategy document

Provide a description of each of the sections to be included in the implementation strategy.

	Section	Description
1	Introduction	
2	Results of assessments to inform the implementation strategy a. Results of needs assessment b. Results of capacity assessment of the organization c. Results of capacity assessment of the external environment	
3	Objectives of the implementation of the competencies and ways to achieve each one	
4	Management of the implementation process	
5	Partnerships and support mechanisms	
6	Monitoring and evaluation framework	*(See instruments 7–9 below for guidance on developing and implementing the monitoring and evaluation framework)*

Instrument 7

Contents of the M&E plan

Provide details of the various sections of the monitoring and evaluation (M&E) plan at the start of the initiative to inform the M&E activities conducted throughout the implementation of the initiative.

	Section	Description
	Basics	
1	Introduction	
2	Results framework	
3	Monitoring plan	
5	Evaluation plan	
7	Roles and responsibilities	
9	Budget	
	Additional items	
4	Data management and analysis	
6	Reporting arrangements	
8	Building of M&E capacities	

Instrument 8

Components of the results framework

Informed by the goal and objectives of the initiative, develop a results framework in which use is made of result-focused statements.

Level[a]	Project-specific details	Indicators (including baseline and target values)	Means of verification	Risks / assumptions (concerning aspects of causal relationships between inputs, outputs, outcomes and impact achievement)
Impact				
Outcome				
Output 1				
Output 2				
Output 3				
Activities				
Inputs (Human, financial and other resources required to implement the initiative)				

[a] "Inputs" are the resources needed for the implementation of activities, including human and financial resources; "outputs" describe the immediate results of implementing activities and are thus within the management control of the intervention; "outcomes" describe those short- and medium-term effects expected to result from the outputs, as such they not completely within the management control of the intervention; "impacts" provide the longer-term effects of the intervention and often relate to improvement in the lives of the population and groups targeted by the intervention.

Instrument 9

Learning tool on the expansion of use of the FP and CAC competencies

Conduct internal sessions and meetings with partners to identify lessons learned in the implementation of the initiative with a focus on use of the FP and CAC competencies.

Learning Question 1:			
Significant observations/ reflections/achievements/ challenges	What worked/did not work? Why? Lessons learned	Necessary adaptations or other actions	Monitoring data/ anecdotes
1a. First session: date and participants			
1b. Second session: date and participants			
Begin with follow-up from 1a before documenting new observations:			
Continue with subsequent sessions…			

Learning Question 2:			
Significant observations/ reflections/achievements/ challenges	What worked/did not work? Why? Lessons learned	Necessary adaptations or other actions	Monitoring data/ anecdotes
2a. First session: date and participants			
2b. Second session: date and participants			
Begin with follow-up from 2a before documenting new observations:			
Continue with subsequent sessions…			

Continue with additional learning questions.

Source: Adapted from ExpandNet. The implementation mapping tool: a tool to support adaptive management and documentation of scale up. ExpandNet; 2020 (https://media.expandnet.net/file/ExpandNet/Main/expandnet-imt-updated-oct-2020.html, accessed 22 June 2023).

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