Accelerating Access to Postpartum Family Planning (PPFP) in Sub-Saharan Africa and Asia

PPFP Country Programming Strategies Worksheet

I. Introduction to the Postpartum Family Planning (PPFP) Country Action Plan

The Postpartum Family Planning (PPFP) Country Programming Strategies Worksheet is an action-driven complement to the resource, *Programming Strategies for Postpartum Family Planning.*

The tool aims to guide country teams of maternal, child and reproductive health policymakers, program managers and champions of family planning in systematically planning country-specific, evidence-based "PPFP Programming Strategies" that can address short interpregnancy intervals and postpartum unmet need and increase postpartum women's access to family planning services. During the meeting, country teams will work together, with an embedded facilitator, on the following activities:

(1) Identify all existing PPFP programs that are already being implemented.

(2) Assess if there are other opportunities/entry points for providing family planning services to women during their postpartum period.

(3) Evaluate those programs in light of a country-level PPFP situational analysis and a health systems Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis to determine whether the same programs, or new or modified programs, should be adopted as the country's future PPFP programs.

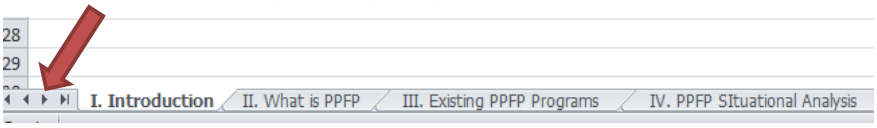
(4) For each of the future PPFP programs, complete a detailed PPFP Implementation Plan and consider how each program can best be scaled up to reach national and global family planning goals.

(5) Create a PPFP Action Plan to document the tasks required and team members responsible for adoption of the PPFP Implementation Plans by relevant decision-makers. The PPFP Action Plan will be revisited and revised during each future meeting of the country team until the PPFP Implementation Plan has been adopted.

Instructions:

1. Please only fill in the cells that are highlighted in yellow.

2. There are 9 separate tabs to assist you in completing your PPFP strategies. To scroll to the next sheet left click on this arrow:



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II. What is PPFP?

PPFP is "the prevention of unintended pregnancy and closely spaced pregnancies through the first 12 months following childbirth," but it can also apply to an "extended" postpartum period up to two years following childbirth. PPFP increases family planning use by reaching couples with family planning methods and messages around and after the time of birth and saves lives by promoting healthy timing and spacing of pregnancies, which is associated with decreased maternal, infant and child mortality. Because women are typically less mobile at least in the early part of the first year postpartum, PPFP programs can benefit greatly from integrating services in both community- and facility-based settings. Such programs must, however, be carefully adapted to the maternal, newborn and child health (MNCH) continuum of care that exists within a given country's health system to foster adoption, implementation and scale-up.

Figure 1. Contact Points for PPFP during the Extended Postpartum Period [WHO 2013]

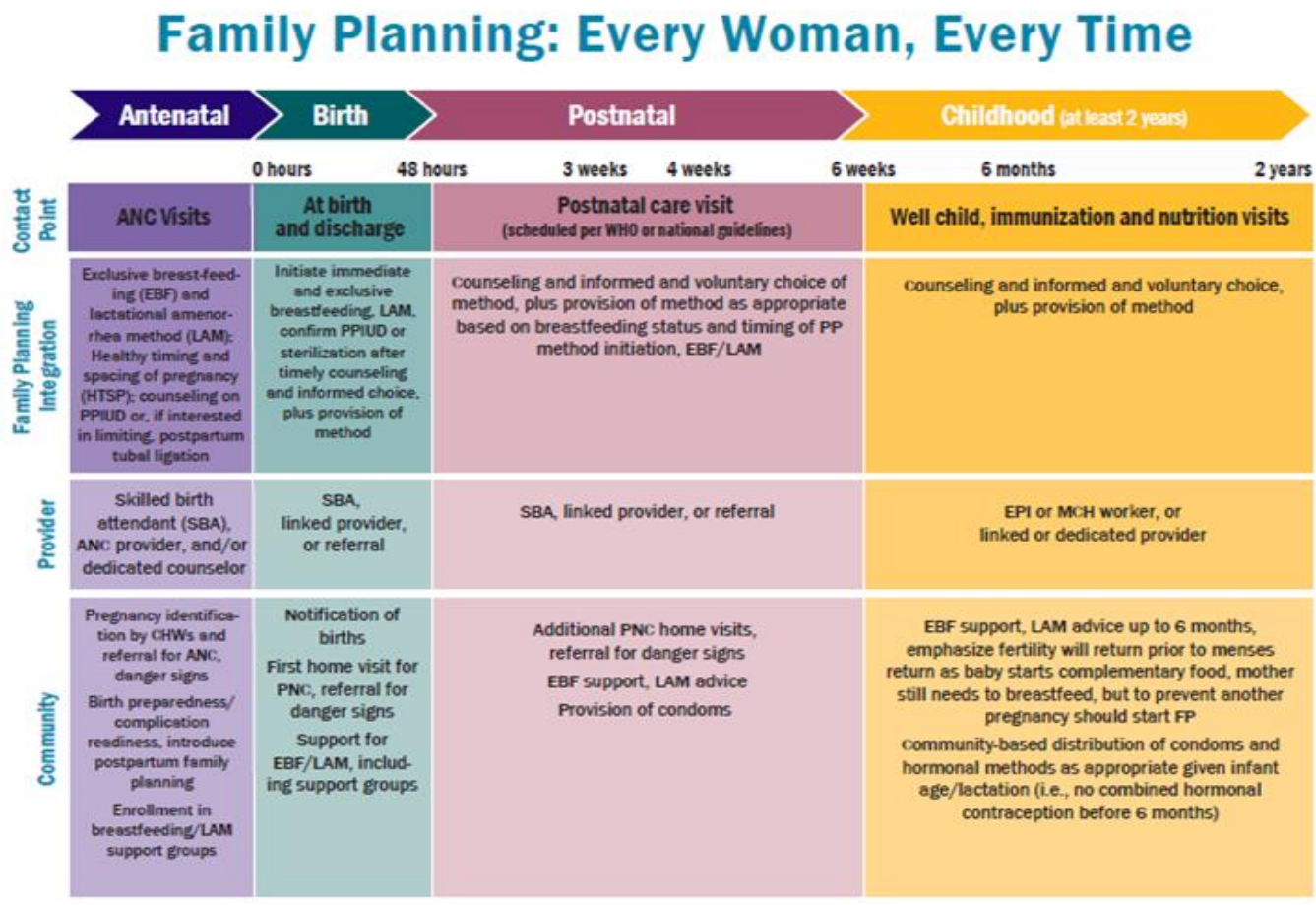
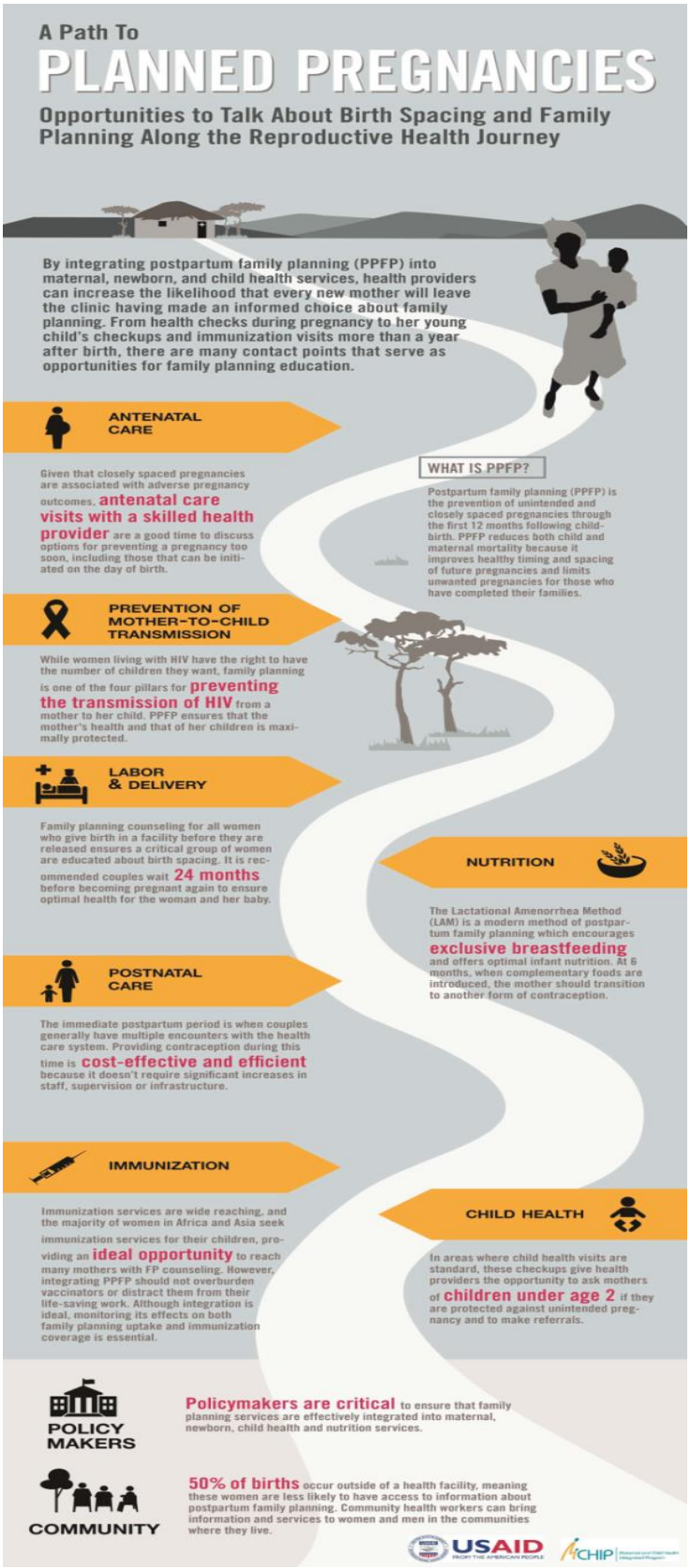


Figure 2. PPFP Integration Opportunities [MCHIP 2013]



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Country:	INDIA	Country Coordinator:	Dr S K Sikdar

III. Existing PPFP Programs

Consider the figures above and review Chapter 3 in *Programming Strategies for Postpartum Family Planning* to determine which PPFP programs already exist in your country. Discuss as many programs as possible with your country team, but list the most promising three programs in the table below and explain the specific activities that have been undertaken to implement each one. Note the key stakeholders (policymakers, program managers, providers, nongovernmental organizations, beneficiaries) who have supported each activity and the organizations that have been involved in implementation. Identify any indicators being used to evaluate whether the program's goals are being achieved.

Existing PPFP Program 1:	**Scaling up PPIUCD services at high delivery points in public sector facilities and introduction in private sector**
Activity 1:	**Building capacity of providers on PPIUCD services in public and private facilities**
Timeframe	**Focused strategy in place since year 2010**
Evidence of success	**1. More than >20000 providers trained in clinical and skill based PPIUCD services and provding services** **2. Introduction and institutionalization of PPIUCD services at two state level sites in 2009 and scaled up to more than 1000 facilities across the country by March 2015.** **3. The scale-up has been rapid with task sharing of PPIUCD services by staff nurses (providers present at point of care) in both public health faciliteis as well as accredited private facilities.**
Total cost over timeframe	
Has this activity been scaled? Why or why not?	**1. Yes; scaled to high delivery load public sector facilites across the country. District Health Action Plans (DHAP) in all states prepared focussing on PPIUCD and other spacing method.** **2. Provision of incentives for PPIUCD for community health worker ASHA and provider.** **3. Provision of dedicated training budget** **4. Provision of logistics and infrastructure budget** **5. Private sector providers in several cities of high focus states mapped.**
Key stakeholders	**GOI, Jhpiego, PSI, HLFPPT, TSU, EH, IPAS**
Implementing agency(ies)	**GOI, Jhpiego, EH, IPAS, HLFPPT**
Activity 2:	**Strengthening PPFP counseling across high delivery load facilites**
Timeframe	**Since 2010**
Evidence of success	**1. Established dedicated counselling corners and placement of dedicated RMNCH+A counsellors at all the high dleivery points across country to provide quality cousneling during Ante Natal and postpartum periods.** **2. Counselling corner -approved by GoI**
Total cost over timeframe	
Has this activity been scaled? Why or why not?	**1. GOI has approved budget in it some high focus states for setting up cosunelling corners and equiping counsellors with counslling aids such as flip books, kits and other IEC logistics for awareness**
Key stakeholders	**GOI, Jhpiego, UHI, PSI,Pathfinder**
Implementing agency(ies)	**GOI, Jhpiego**

Activity 3:	**De-centralized PPIUCD training capacity in all states with provision of onsite trainings**
Timeframe	**In last one year high focus states have established one training site at each division of the state**
Evidence of success	**1. More than 100 state/division/district level training sites estalished across country and eqipped with development of master trainers and all relevant trainings aids**
Total cost over timeframe	
Has this activity been scaled? Why or why not?	**1. GOI has approved establishment of decentralized training capacity upto district level** **2. On-site training -8 states with DPs; rest by GoI.**
Key stakeholders	**GoI, Jhpiego,**
Implementing agency(ies)	**Jhpiego, GOI**
Indicator(s) (Data Source):	**1. PPIUCD acceptance among institutional deliveries. Source: HMIS** **2. Percent trained providers providing PPIUCD services. Source: Program Reports**
Existing PPFP Program 2:	**Demand generation and integration of PPFP program at different MNH platform and doorstep delivery of contraceptives through frontline workers**
Activity 1:	**Distribution of modern contraceptives at the doorstep of communities**
Timeframe	**Since 2011**
Evidence of success	**Reasonable level of scale up of this strategy in high focus states. More than 8 million ASHAs are now distributing contraceptives at the doorstep of beneficiary**
Total cost over timeframe	
Has this activity been scaled? Why or why not?	**YES, the scheme is operational in all states of India.**
Key stakeholders	**GoI**
Implementing agency(ies)	**States**
Activity 3:	**Utilizing ASHAs for counselling the beneficiaries on benefits of healthy spacing and post partum family planning options**
Timeframe	**Since 2012**
Evidence of success	**Scheme for Ensuring spacing at birth is operational in 18 High focus states of India. More than 6 million ASHAs are counselling the beneficiaries at field level.**
Total cost over timeframe	
Has this activity been scaled? Why or why not?	
Key stakeholders	**GoI**
Implementing agency(ies)	**States**

Indicator(s) (Data Source):	**% of ASHA's providing modern contraceptives by method**
Existing PPFP Program 4:	**Provision of injectables as a modern family planning method for postpartum women in Private sector**
Activity 1:	**Injectables are being promoted as additional choice for PP contraception in private sector**
Timeframe	
Evidence of success	**1. Providers in the private health sector are being trained on service provision for long term injectables.**
Total cost over timeframe	
Has this activity been scaled? Why or why not?	**Private sector providers in several cities of high focus states mapped and trained in the service provision for injectables.**
Key stakeholders	**GOI, Abt Associates, ARTH, FOGSI**
Implementing agency(ies)	**Abt Associates, ARTH**
Activity 2:	
Timeframe	
Evidence of success	
Total cost over timeframe	
Has this activity been scaled? Why or why not?	
Key stakeholders	
Implementing agency(ies)	
Activity 3:	
Timeframe	
Evidence of success	
Total cost over timeframe	
Has this activity been scaled? Why or why not?	
Key stakeholders	
Implementing agency(ies)	
Indicator(s) (Data Source):	

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IV. PPFP Situational Analysis

Successful PPFP programs align with the demographic characteristics of the postpartum population within a country and are adapted to the country's governance context. The following table extracts the demographic and family planning governance data that should influence program plans. Fill in the data response that your country team agrees upon and provide the source used if is different from or more specific than the one listed. ***See Tab IX for select suggested data responses.***

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
DEMOGRAPHIC DATA				
1	Total population (as of mid-2014)	Population Reference Bureau (see Tab IX)	1,296,245,000	Population that will benefit from families reaching desired size
2	Annual population growth, %	Population Reference Bureau "Rate of Natural Increase" (see Tab IX)	1.5	Pace of population change that could be slowed with PPFP
3	Crude birth rate	Population Reference Bureau (see Tab IX)	22	Numbers of births occurring
4	Number of women of reproductive age (WRA)	Population Reference Bureau (see Tab IX)	323,600,000	Population with future potential to need PPFP to reach desired family size and reduce maternal and child health risks
5	Number of WRA who are pregnant	Calculated from Population Reference Bureau (see Tab IX)	28,517,390	Population with immediate potential to need PPFP to reach desired family size and reduce maternal and child health risks
6	Total fertility rate	Demographic and Health Survey (see Tab IX)	2.7	Number of births per woman with opportunity for PPFP—compare with #7 on ideal family size
7	Ideal family size	Demographic and Health Survey (see Tab IX)	2	Compare with #6 on total fertility rate

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
8	Adolescent fertility rate	Population Reference Bureau (see Tab IX)	73	Number of births per girl ages 15–19 with opportunity for PPFP (Also consider what proportion of this are births to girls <18 as those with highest maternal mortality risk.)
9	Percentage of birth-to-next-pregnancy (interpregnancy) interval of: ➢ 7–17 months ➢ 18–23 months ➢ 24–35 months ➢ 36–47 months	Demographic and Health Survey (see Tab IX)	➢ 7-17 months: 11 ➢ 18–23 months: 16 ➢ 24–35 months: 34 ➢ 36–47 months: 19	Optimal birth-to-pregnancy (interpregnancy) intervals are 24 months or longer, so those 23 months or less are too short and are riskiest for mother and child (Consider lack of awareness of this risk or access to family planning among postpartum WRA.)
10	Percentage of first births in women: ➢ 15–19 years old ➢ 20–23 years old ➢ 24–29 years old ➢ 30–34 years old	Demographic and Health Survey (see Tab IX)	➢ 25–29 years old: 19.9 ➢ 30–34 years old: 20.0	Population of first-time parents who can receive PPFP early and often as they reach desired family size
11	Percentage of unmet need among WRA	Demographic and Health Survey (see Tab IX)	13.9	Population of women who do not want to become pregnant and who are not using family planning—levels above 10% suggest low effectiveness of family planning efforts
12	Percentage of unmet need for: ➢ spacing ➢ limiting	Demographic and Health Survey (see Tab IX)	➢ spacing: 6.1 ➢ limiting: 8.0	Distinguishes women with unmet need who wish to have children in the future ("spacers") from those who wish to avoid future pregnancies ("limiters")—levels should be compared with method mix in #16 to determine whether reaching women with the right method at the right time
13	Percentage of postpartum prospective unmet need	Z. Moore et al., Contraception 2015		Population of women who *currently* need PPFP to reach desired family size and reduce maternal and child health risks

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
14	Contraceptive prevalence rate	Demographic and Health Survey (see Tab IX)	Any Method: 56.30 Modern Method: 48.50	Population of women who are currently using family planning
15	Your country's CPR target	Government website or other publicly available reference	**63.7 by the year 2020**	Population of women who are expected to use family planning (postpartum or otherwise) by a certain date—consider gap from #14
16	Contraceptive prevalence rate for: ➢ Short-acting contraception ➢ Long-acting, reversible contraception (LARC) ➢ Lactational amenorrhea method (LAM) ➢ Permanent contraception	Demographic and Health Survey (see Tab IX)	➢ Short-acting contraception: 8.40 ➢ Long-acting, reversible contraception (LARC): 1.70 ➢ Lactational amenorrhea method (LAM): 14.90 ➢ Permanent contraception: 38.30	Current method mix, especially interest in contrasting use of permanent methods against #12, unmet need for limiting, and the more effective yet reversible LARCs, and potential for transition from LAM to other methods such as LARCs to reach desired family size and reduce maternal and child health risks (Also consider coverall method mix, e.g., the number of methods that are used by >20% of family planning users.)
17	Percentage of women who receive at least one antenatal care visit	Demographic and Health Survey (see Tab IX)	6.4	Population that can be reached with PPFP messages early in the MNCH continuum of care and receive service after delivery with systematic implementation
18	Percentage of women practicing exclusive breastfeeding (EBF) at: ➢ 2 months ➢ 5–6 months	Demographic and Health Survey (see Tab IX)	➢ 2 months: 58.30 ➢ 5–6 months: 23.30	Consider whether a family planning strategy promoting LAM (i.e., 6 months of EBF before return of menses) could potentially increase duration of EBF and produce child and maternal health benefits beyond birth spacing.
19	Percentage of deliveries in health facilities	Demographic and Health Survey (see Tab IX)	6.3	Population that can be reached with PPFP methods on the "day of birth," including LARCs—can be broken down by age, residence and wealth quintiles to highlight underserved groups.

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
20	Percentage of deliveries at home	Demographic and Health Survey (see Tab IX)	59	Population that can be reached with community-based promotion of PPFP—can be broken down by age, residence and wealth quintiles to highlight underserved groups.
21	Percentage of women who receive at least one postnatal care visit	Possibly Demographic and Health Survey; if not, use other available data or estimations	33.8% (UP DLHS 2009) 26.2% (Bihar DLHS-3)	Population that can be reached after birth with PPFP counseling and services other than at routine immunization visits
22	Percentage of women who receive a postnatal care visit at: ➢ 0–23 hours ➢ 1–2 days ➢ 3–6 days ➢ 7–41 days ➢ 42 days (6 weeks)	Possibly Demographic and Health Survey; if not, use other available data or estimations	➢ 1–2 days: 36.8%	Population that can be reached with certain PPFP methods that are available in the immediate postpartum period (i.e., prior to discharge) or that need to be introduced at later contact points
23	Immunization rates for: ➢ Birth BCG ➢ DPT1 ➢ DPT3 ➢ Drop-out rate between DPT1 & DPT3	Demographic and Health Survey (see Tab IX)	➢ Birth BCG: 78.1 ➢ DPT1: 76 ➢ DPT3: 55.30 ➢ Drop-out rate between DPT1 & DPT3: 20.70	Population that can be reached with PPFP methods at routine immunization visits or through referrals from these visits
24	OPTIONAL: Percentage of women who experience violence during pregnancy, childbirth or for using family planning	Possibly Demographic and Health Survey; if not, use other available data or estimations		Importance of sensitizing health workers to this population, including possible reproductive coercion and preparing them to sensitively discuss gender-based violence mitigation or prevention strategies integrated with PNC/PPFP services. Also role of discreet/clandestine methods for these women.
25	Percentage of unsafe abortions	WHO, Unsafe Abortion, 2008 http://whqlibdoc.who.int/publications/2011/9789241501118_eng.pdf?ua=1 [regional estimates only]	Unsafe Abortion Rate: 26 per 1000 women aged 15-44 yrs Unsafe abortion ratio: 33 per 100 live births	Population that is at high maternal mortality risk and is likely to need postabortion care, including FP services
GOVERNANCE DATA				

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
26	FP2020 Commitment	http://www.familyplanning2020.org/reaching-the-goal/commitments	More than USD 2 Billion	Country-level, public financial commitment to invest in FP
27	Statement for Collective Action for PPFP Country Endorsement	http://www.mchip.net/actionppfp/		Country-level, public support/champions for PPFP
28	National FP Strategy	Government website or other publicly available citation	**Already in Place**	Where PPFP should be included or enhanced to affect national policy
29	FP Costed Implementation Plan	Government website or other publicly available citation	**Already in Place**	Where PPFP programs with budgets should be included or enhanced to affect national policy
30	Provide PPFP Implication for: "Provider cadres that are authorized to deliver PPFP services"	http://www.optimizemnh.org/intervention.php		

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Country:	INDIA	Country Coordinator:	Dr Somesh Kumar

V. Health Systems "SWOT" Analysis

The structure of a country's health system greatly affects whether PPFP programs succeed, particularly as implementation moves to scale. Use the table below to conduct a Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis of each of the existing PPFP programs in sheet III. Existing PPFP Programs. List the internal strengths and weaknesses and the external opportunities and threats of each program from each health system dimension. For guiding questions, consult Section 2.2 in Chapter 2 of *Programming Strategies for Postpartum Family Planning* .

Existing PPFP Program - relevant to all streams:	**Scaling up PPIUCD services at high delivery points in public sector facilities and introduction in private sector**

	Health System Dimension	**Strengths**	**Weaknesses**	**Opportunities**	**Threats**
1	Health Services				
	a. Public sector	High level of ownership	Inadequate number and capacity of providers	Increase in institutional deliveries	Appropriate resoruce allocation to match the scale of scale-up
		Increased allocation in program budget	Low Technomanagerial capaciy at state and district level	Dispropotionately high unmet need in the immediate postpartum period	
		Presence of public health facilities leading High level of access to public sector health services; credibility high in many states	Weak iintegartion at various MNH platforms	Availibility of skilled birth attendants	
	b. Faith-based/non-governmental organization (NGO)	Increasing participation of various agencies in supporting the PPFP strategy	Patchy coordination among agencies	Synergistic approach to the PPFP program for integration at various platfoms for greater access and improved outcomesand improve coordination	Continuity of Funding
	c. Private sector	Large presence across country	Unorganized	Interest to participate in the program	Access for marginalized population
		Presence of skilled birth attendents	No uniform policy for accreditation		Out of pocket expenses
2	Health management information system (HMIS)	Present across the public health system	1. Captures limited number of PPF indicators 2. Quality of Data	Timely access to data for analysis for decision making and program steering Access to live/real time data	
3	Health workforce	Presence upto the community level	Competency of serivce providers Irrational distribution of health workforce	Integration in community based programs	
4	Medicines and technology				
5	Health financing	Increasing funds allocation. Decentralized allocation of funds	Limited knowledge of program mangers on fund utilization. Weak convergence of the program implementors and financial planners.	Availability of multiple pools of funds (State funding/Central Funding/Technical support by DP)	
6	Leadership and governance	Strong leadership. Uniform program policies Free access of Mandatory disclosure for the health activities RTI act for ensuring transperancy	Varying capacities/leaderships of different states FP is at the low priority in few states Low public/private interface	System of state review for better participation Presence of DP and CSO and their involvement in decentralized planning.	
7	Community and sociocultural				
	a. Community-based				

Health System Dimension		Strengths	Weaknesses	Opportunities	Threats
7	b. Mobile outreach				
	c. Social marketing				

Existing PPFP Program 2:	Strengthening PPS service provision at public sector health facilities

Health System Dimension		Strengths	Weaknesses	Opportunities	Threats
1	Health Services				
	a. Public sector				
	b. Faith-based/NGO				
	c. Private sector				
2	HMIS				
3	Health workforce				
4	Medicines and technology				
5	Health financing				
6	Leadership and governance				
7	Community and Sociocultural				
	a. Community-based				
	b. Mobile outreach				
	c. Social marketing				

Existing PPFP Program 3:	Demand generation and integration of PPFP program at different MNH platform and doorstep delivery of contraceptives through frontline workers

Health System Dimension		Strengths	Weaknesses	Opportunities	Threats
1	Health Services				
	a. Public sector				

Health System Dimension		Strengths	Weaknesses	Opportunities	Threats
1	b. Faith-based/NGO				
	c. Private sector				
2	HMIS				
3	Health workforce				
4	Medicines and technology				
5	Health financing				
6	Leadership and governance				
7	Community and Sociocultural				
	a. Community-based				
	b. Mobile outreach				
	c. Social marketing				

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PPFP Country Programming Strategies Worksheet

Country:	India	Country Coordinator:	Dr. SK Sikdar

VI. PPFP Implementation Plan

Reflect on both the PPFP situational analysis on sheet III. and the SWOT analysis on sheet V. to evaluate whether your country's existing PPFP programs can be improved, or whether entirely new programs should be proposed. For example, given your country's context:

1. Should the existing programs better target certain hard-to-reach or underserved populations?
2. Are there better contact points for PPFP integration than the ones used in existing programs?
3. Which contraceptive methods are likely to be most acceptable and available in the settings where women deliver in your country?
4. What additional health strengthening activities are needed to institutionalize each strategy?
5. What additional resources and sources of funds can be requested in annual budgeting processes?
6. Are there new key stakeholders who could be engaged?
7. Are there other implementing organizations that might be interested in PPFP activities?

In this sheet, either revise your existing PPFP programs from sheet IV. or substitute alternative programs as your country's future PPFP programs. Carry over any activities that already are achieving a program goal but take a prospective view on their implementation when revising the remaining details. Add as many new activities are needed. To help determine "total cost over timeframe," visit: http://www.fhi360.org/resource/costed-implementation-plans-guidance-and-lessons-learned. This table will be the start of your country's PPFP Implementation Plan.

Future PPFP Program 1: Expanding Access to more PPFP methods at public sector health facilities	
Objective 1:	**Scale up of PPIUCD services to ALL public sector delivery points of the country**
Timeframe	**3 years**
Evidence of success	**PPIUCD acceptance rate of 10% in at least 50% of delivery points**
Total cost over timeframe	
Additional considerations	**Training of more number of Nurses in all the delivery points**
Key stakeholders	**GoI, States, Donors, DPs-Jhpiego, EH, IPAS, HLFPPT…**
Implementing agency(ies)	**GoI, States**
Objective 2:	**Revitalization and Scale up of PPS services in high delivery points (all DH and FRUs/Block PHCs with minilap providers) of Six High Focus states**
Timeframe	**5 years**
Evidence of success	**5% acceptance rates in the targeted facilities**
Total cost over timeframe	
Additional considerations	**1. Existing minilap providers to be trained on 3 day PPS training for accelerated start up of PPS services** **2. Provider base of minilap providers to be increased by the 12 day training**
Key stakeholders	**GoI. States, Donors, DPs**
Implementing agency(ies)	**GoI, Six High focus States**
Objective 3:	**Strengthening of utilization of DATA for PPFP program**
Timeframe	

Evidence of success	New data elements on PPFP integrated in data collection system.
Total cost over timeframe	
Additional considerations	Facility based PPFP Dashboard to be created
Key stakeholders	GoI, States, Donors, DPs
Implementing agency(ies)	GoI, States
Objective 4:	Scale up Post Abortion Family Planning Services
Timeframe	
Evidence of success	New data elements on PAFP integrated in data collection system.
Total cost over timeframe	
Additional considerations	Facility based PAFP Dashboard to be created
Key stakeholders	GoI, States, Donors, DPs
Implementing agency(ies)	GoI, States
Indicator(s) for this objective (Data Source):	(1) % of institutional deliveries accepting PPIUCD services. (2) % of institutional deliveries accepting PPS services. (3) % of PPIUCD acceptors followed up at 6 weeks. (4) % PPIUCD/PPS acceptors counselled during ANC. (5) % of beneficiaries accepting PAFP out of the total abortion cases.
Future PPFP Program 2: Strengthening Demand Generation	
Objective 1:	Integration of PPFP services in existing RMNCHA service delivery platforms
Activity 1:	Involvement of Front line health workers for demand generation-ANMs, ASHAs-in six high focus states
Timeframe	5 years
Evidence of success	Increase in ESB, PPS, PPIUCD incentive utilization.
Total cost over timeframe	
KEY ACTIVITIES	1. Undertake dedicated training of ASHAs and ANMs on PPFP along with information of PPFP incentives; 2 Tying up of PPFP messages with HDC; 3. Prepare lean resource material and job-aids; 4. Develop guidance ASHAs for involvment of males, MILs as a part of ESB
Key stakeholders	GoI, NHSRC, States, Donors, DPs.
Implementing agency(ies)	GoI, NHSRC, States
Activity 2:	Increasing the uptake of Post partum Sterilization

Timeframe	24 months
Evidence of success	High acceptance of PPS services in Southern part of India.
Total cost over timeframe	
Additional considerations	Increase the provider bas for Minilap services
Key stakeholders	GoI, States
Implementing agency(ies)	GoI, States
Activity 3:	Recruitment of RMNCH+A counsellors in all the high delivery load facilities and a system which allows integration of the same with community health workers
Timeframe	
Evidence of success	Availability of counsellors at all high delivery load facilities for counselling at antenatal and post natal period
Total cost over timeframe	
Additional considerations	
Key stakeholders	GoI, States, Donors, DPs
Implementing agency(ies)	GoI, States
Activity 4:	Integration of PPFP counseling into ANC/PNC Platform
Timeframe	24 months
Evidence of success	30% of PPS/ PPIUCD Acceptors counselled during ANC. All the ANC clinics and VHND Equipped with PPFP counselling material.
Total cost over timeframe	
Additional considerations	1. ANC card to capture the information of PPFP Counselling PPFP counselling material for ASHA for counselling during HBNC Visits.
Key stakeholders	GoI, States, Donors, DPs
Implementing agency(ies)	GoI, States

CROSSCUTTING ACTIVITY FOR INTEGRATION: Training of ASHAs, ANMs, ASHA Coordinators, Block Community Mobilizers for integration of PPFP messages into ANC, Immunization, HBPNC, BCC for exclusive breast feeding and Equipping them with Job-Aids.

Future PPFP Program 3: Introduction of new methods and Involvement of Private Sector

Activity 1:	**Explporing the possibility of introducing Centchromen**
Timeframe	**24 months**
Evidence of success	**Pilot of Centchromen service delivery initiated**
Total cost over timeframe	
Additional considerations	
Key stakeholders	**GoI, Donors, DPs**
Implementing agency(ies)	**GoI**
Activity 2:	
Timeframe	
Evidence of success	
Total cost over timeframe	
Additional considerations	
Key stakeholders	
Implementing agency(ies)	

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PPFP Country Programming Strategies Worksheet

Country:	India	Country Coordinator:	

VII. Considerations for Scale-up

Consult "Beginning with the end in mind" (or "Nine steps for developing a scaling-up strategy") to understand the factors that might affect the scale of each of your country's future PPFP programs. Consider the framework and elements for scale-up depicted

	Scale-up Consideration	Yes	No	More Information/Action Needed
Future PPFP Program 1:				
1	Is input about the program being sought from a range of stakeholders?			
2	Are individuals from the implementing agency(ies) involved in the program's design and implementation?			
3	Does the program have mechanisms for building ownership in the implementing agency(ies)?			
4	Does the program address a persistent health or service delivery problem?			
5	Is the program based on sound evidence and preferable to alternative approaches?			
6	Given its financial and human resource requirements, is the program feasible in the local settings where it is to be implemented?			
7	Is the program consistent with existing national health policies, plans and priorities?			
8	Is the program being designed in light of agreed-upon stakeholder expectations for where and to what extent activities are to be scaled-up?			
9	Does the program identify and take into consideration community, cultural and gender factors that might constrain or support its implementation?			
10	Have the norms, values and operational culture of the implementing agency(ies) been taken into account in the program's design?			
11	Have the opportunities and constraints of the political, policy, health-sector and other institutional factors been considered in designing the program?			

	Scale-up Consideration	Yes	No	More Information/Action Needed
12	Have the activities for implementing the program been kept as simple as possible without jeopardizing outcomes?			
13	Is the program being implemented in the variety of sociocultural and geographic settings where it will be scaled up?			
14	Is the program being implemented in the type of service-delivery points and institutional settings in which it will be scaled up?			
15	Does the program require human and financial resources that can reasonably be expected to be available during scale-up?			
16	Will the financing of the program be sustainable?			
17	Does the health system currently have the capacity to implement the program? If not, are there plans to test ways to increase health-systems capacity?			
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?			
19	Is there provision for early and continuous engagement with donors and technical partners to build a broad base of financial support for scale-up?			
20	Are there plans to advocate for changes in policies, regulations and other health-systems components needed to institutionalize the program?			
21	Does the program include mechanisms to review progress and incorporate new learning into its implementation process?			
22	Is there a plan to share findings and insights from the program during implementation?			
23	Is there a shared understanding among key stakeholders about the importance of having adequate evidence related to the feasibility and outcomes of the program prior to scaling up?			
	Scale-up Consideration	**Yes**	**No**	**More Information/Action Needed**
Future PPFP Program 2:				
1	Is input about the program being sought from a range of stakeholders?			

	Scale-up Consideration	Yes	No	More Information/Action Needed
2	Are individuals from the implementing agency(ies) involved in the program's design and implementation?			
3	Does the program have mechanisms for building ownership in the implementing agency(ies)?			
4	Does the program address a persistent health or service delivery problem?			
5	Is the program based on sound evidence and preferable to alternative approaches?			
6	Given its financial and human resource requirements, is the program feasible in the local settings where it is to be implemented?			
7	Is the program consistent with existing national health policies, plans and priorities?			
8	Is the program being designed in light of agreed-upon stakholder expectations for where and to what extent activities are to be scaled-up?			
9	Does the program identify and take into consideration community, cultural and gender factors that might constrain or support its implementation?			
10	Have the norms, values and operational cultrue of the implementing agency(ies) been taken into account in the program's design?			
11	Have the opportunities and constraints of the political, policy, health-sector and other institutional factors been considered in designing the program?			
12	Have the activities for implementing the program been kept as simple as possible without jeopardizing outcomes?			
13	Is the program being implemented in the variety of sociocultural and geographic settings where it will be scaled up?			
14	Is the program being implemented in the type of service-delivery points and institutional settings in which it will be scaled up?			
15	Does the program require human and financial resources that can reasonably be expected to be available during scale-up?			

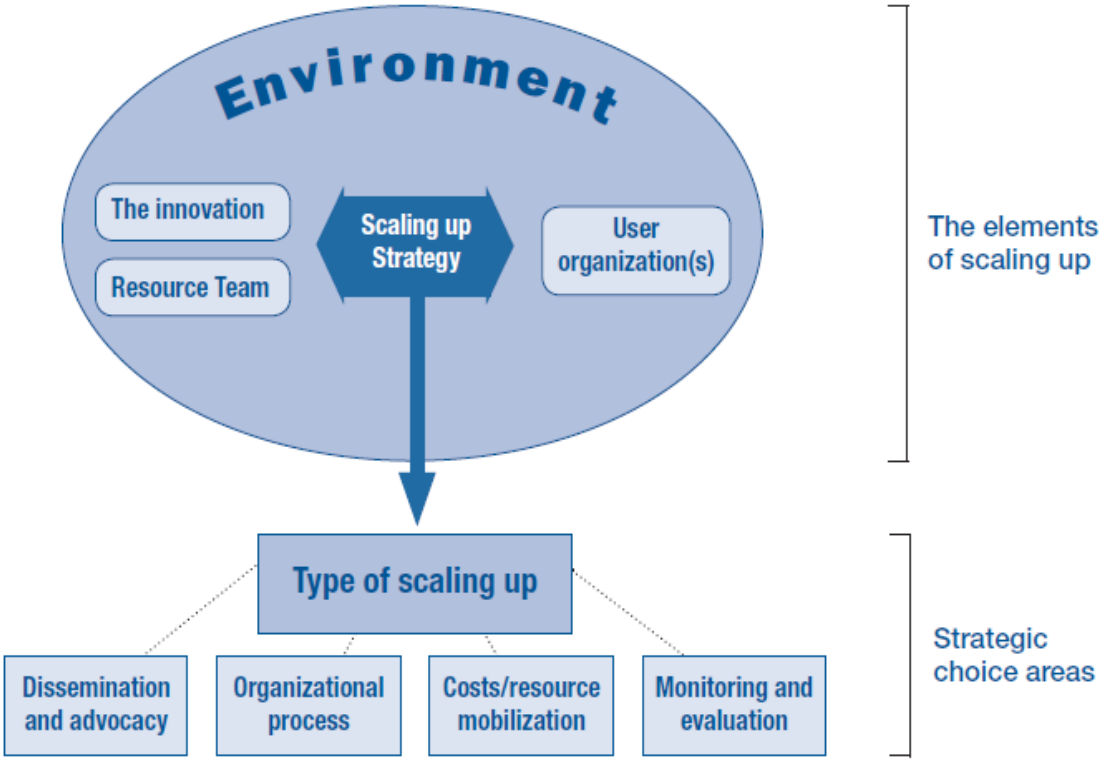
	Scale-up Consideration	Yes	No	More Information/Action Needed
16	Will the financing of the program be sustainable?			
17	Does the health system currently have the capacity to implement the program? If not, are there plans to test ways to increase health-systems capacity?			
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?			
19	Is there provision for early and continuous engagement with donors and technical partners to build a broad base of financial support for scale-up?			
20	Are there plans to advocate for changes in policies, regulations and other health-systems components needed to institutionalize the program?			
21	Does the program include mechanisms to review progress and incorporate new learning into its implementation process?			
22	Is there a plan to share findings and insights from the program during implementation?			
23	Is there a shared understanding among key stakeholders about the importance of having adequate evidence related to the feasibility and outcomes of the program prior to scaling up?			

	Scale-up Consideration	Yes	No	More information/action needed
Future PPFP Program 3:				
1	Is input about the program being sought from a range of stakeholders?			
2	Are individuals from the implementing agency(ies) involved in the program's design and implementation?			
3	Does the program have mechanisms for building ownership in the implementing agency(ies)?			
4	Does the program address a persistent health or service delivery problem?			
5	Is the program based on sound evidence and preferable to alternative approaches?			

	Scale-up Consideration	Yes	No	More Information/Action Needed
6	Given its financial and human resource requirements, is the program feasible in the local settings where it is to be implemented?			
7	Is the program consistent with existing national health policies, plans and priorities?			
8	Is the program being designed in light of agreed-upon stakholder expectations for where and to what extent activities are to be scaled-up?			
9	Does the program identify and take into consideration community, cultural and gender factors that might constrain or support its implementation?			
10	Have the norms, values and operational cultrue of the implementing agency(ies) been taken into account in the program's design?			
11	Have the opportunities and constraints of the political, policy, health-sector and other institutional factors been considered in designing the program?			
12	Have the activities for implementing the program been kept as simple as possible without jeopardizing outcomes?			
13	Is the program being implemented in the variety of sociocultural and geographic settings where it will be scaled up?			
14	Is the program being implemented in the type of service-delivery points and institutional settings in which it will be scaled up?			
15	Does the program require human and financial resources that can reasonably be expected to be available during scale-up?			
16	Will the financing of the program be sustainable?			
17	Does the health system currently have the capacity to implement the program? If not, are there plans to test ways to increase health-systems capacity?			
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?			
19	Is there provision for early and continuous engagement with donors and technical partners to build a broad base of financial support for scale-up?			

	Scale-up Consideration	Yes	No	More Information/Action Needed
20	Are there plans to advocate for changes in policies, regulations and other health-systems components needed to institutionalize the program?			
21	Does the program include mechanisms to review progress and incorporate new learning into its implementation process?			
22	Is there a plan to share findings and insights from the program during implementation?			
23	Is there a shared understanding among key stakeholders about the importance of having adequate evidence related to the feasibility and outcomes of the program prior to scaling up?			

Figure 3. ExpandNet/WHO Framework for Scale-up [WHO 2010]



Accelerating Access to Postpartum Family Planning (PPFP) in Sub-Saharan Africa and Asia

PPFP Country Programming Strategies Worksheet

Country:	India	Country Coordinator:	

VIII. PPFP Action Plan

The PPFP Implementation Plan started in sheet VI. will have missing or temporary information that your country team needs to complete, and the final plan will also need to be adopted by all stakeholders and implementing agencies involved. In the table below, identify all remaining tasks and assign both a primary and secondary member of the team responsible for its execution by a given deadline.

	Task	Primary person responsible	Secondary person responsible	Deadline	What problems do you anticipate? What will you do when you encounter these (or other) problems?
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

	Task	Primary person responsible	Secondary person responsible	Deadline	What problems do you anticipate? What will you do when you encounter these (or other) problems?
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					