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.

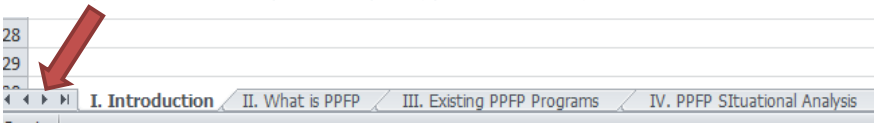
(4) For each of the future PPFP programs, complete a detailed PPFP Implementation Plan and consider how each program can best be scaled up to reach national and global family planning goals.

(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]

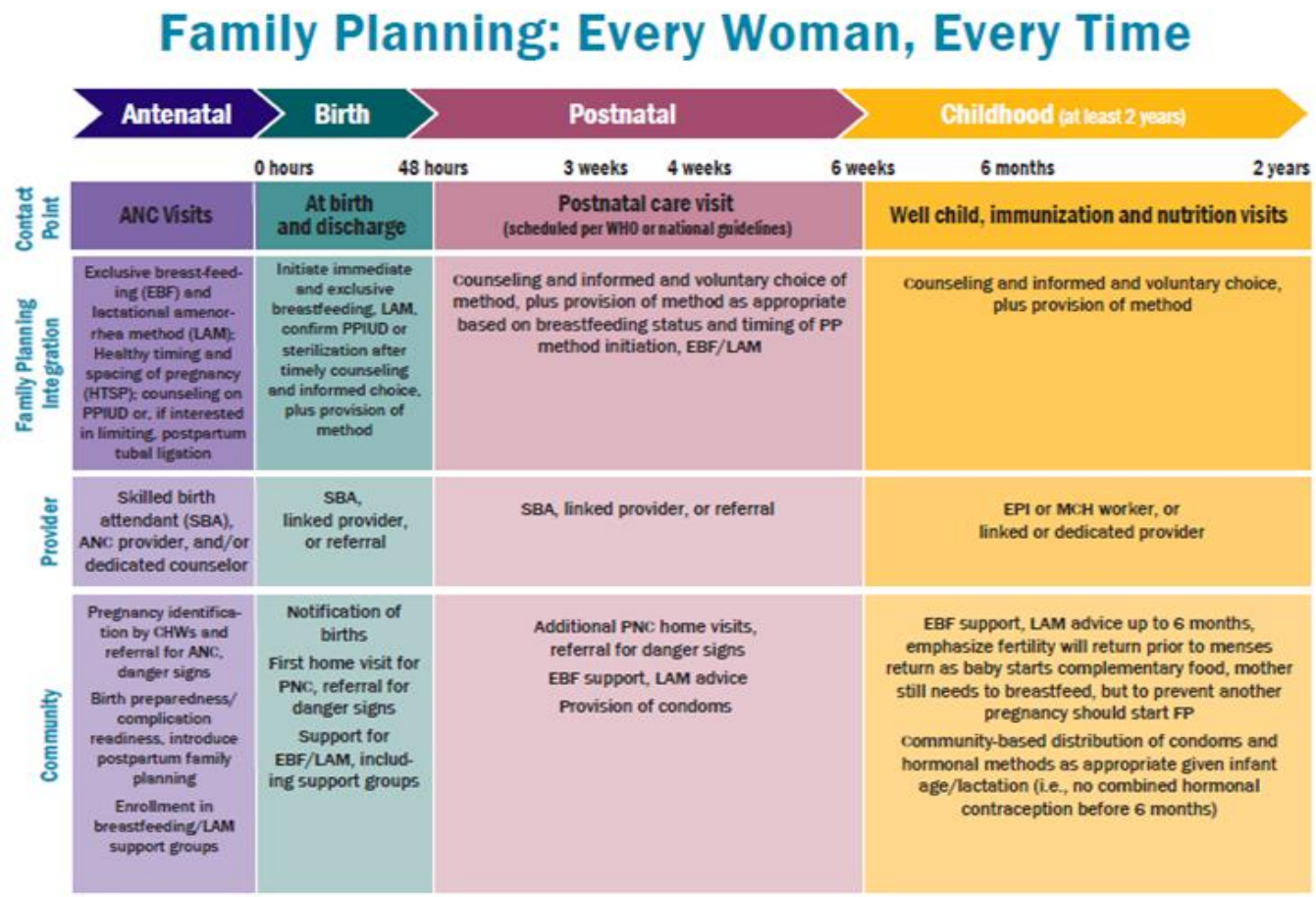
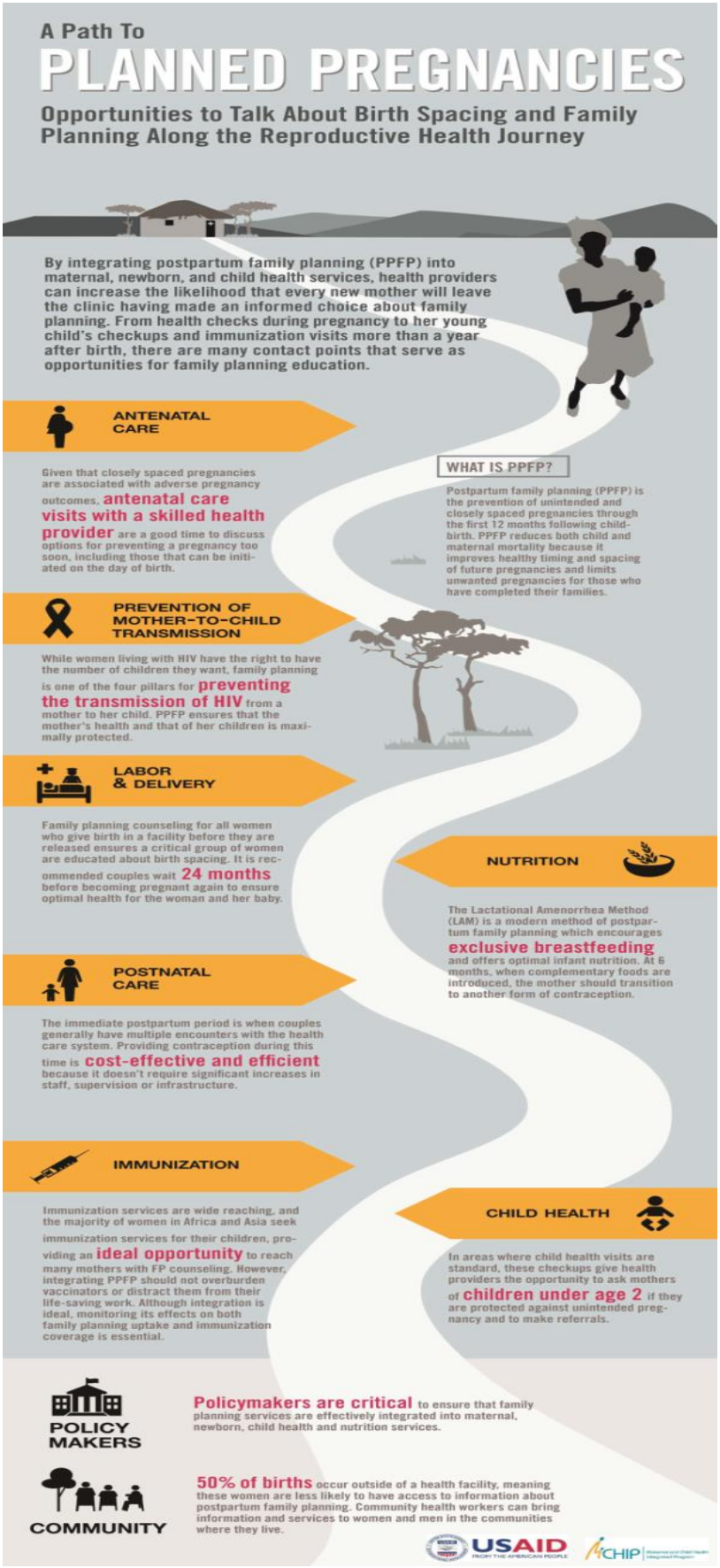


Figure 2. PPFP Integration Opportunities [MCHIP 2013]



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Country:	Kenya	Country Coordinator:	

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:	**Kenya Urban Reproductive Health Initative**
Activity 1:	**Training Health Workers and CHVs on Post partum FP; Supporting CHVs to promote PPFP at community level**
Timeframe	**2010 - 2015**
Evidence of success	**Increase in CPR by post partum women ; No. of post partum women referred for FP;**
Total cost over timeframe	**N/A - Was part of FP strategies for the project ;**
Has this activity been scaled? Why or why not?	**Not yet.**
Key stakeholders	**Ministry of Health, RMHSU, Community Strategy Division**
Implementing agency(ies)	**Jhpiego**
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):	
Existing PPFP Program 2:	USAID's MCHIP and MCSP
Activity 1:	Service strengthening and service provider training for provision of PPIUCD
Timeframe	2009-2010
Evidence of success	Trained staff achieved competency and cascaded the training.
Total cost over timeframe	100,000 USD
Has this activity been scaled? Why or why not?	Although cascading of the training was donewithin the facility, efforts to cascade outside the trained facility have been limited. This has been due to high staff turn over and limited resources. Under MCSP, this will however be scaled up to four regions.
Key stakeholders	MoH leadership, service providers, PIUCD champions, CHVs, women
Implementing agency(ies)	MCHIP
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):	

Existing PPFP Program 3:	
Activity 1:	
Timeframe	
Evidence of success	
Total cost over timeframe	
Has this activity been scaled? Why or why not?	
Key stakeholders	
Implementing agency(ies)	
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)	38,610,097	Population that will benefit from families reaching desired size
2	Annual population growth, %	Population Reference Bureau "Rate of Natural Increase" (see Tab IX)	1.70%	Pace of population change that could be slowed with PPFP
3	Crude birth rate	Population Reference Bureau (see Tab IX)	1,800,000	Numbers of births occurring
4	Number of women of reproductive age (WRA)	Population Reference Bureau (see Tab IX)	9,375,784	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)	1,800,000	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)	3.9	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)		Compare with #6 on total fertility rate
8	Adolescent fertility rate	Population Reference Bureau (see Tab IX)	18%	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.)

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
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)	N/A	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)	N/A	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)	18%	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)	N/A	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	N/A	Population of women who *currently* need PPFP to reach desired family size and reduce maternal and child health risks
14	Contraceptive prevalence rate	Demographic and Health Survey (see Tab IX)	58%	Population of women who are currently using family planning
15	Your country's CPR target	Government website or other publicly available reference	56%	Population of women who are expected to use family planning (postpartum or otherwise) by a certain date—consider gap from #14

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
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- 36% LARC-10% LAM- 0.1% Permanent Contraception- 3.2%	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)	96%	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= 84.1% > 5-6 months = 61%	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)	61%	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.
20	Percentage of deliveries at home	Demographic and Health Survey (see Tab IX)	39%	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	51%	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= 51%	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

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
23	Immunization rates for: ➢ Birth BCG ➢ DPT1 ➢ DPT3 ➢ Drop-out rate between DPT1 & DPT3	Demographic and Health Survey (see Tab IX)	BCG=96.7% DPT 1= 97.5% DPT 3= 89.9% Drop-out Rate= 7.6%	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	Check DHS, Dr Ongech, Dr Mackanyengo	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]	16%	Population that is at high maternal mortality risk and is likely to need postabortion care, including FP services
GOVERNANCE DATA				
26	FP2020 Commitment	http://www.familyplanning2020.org/reaching-the-goal/commitments		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		Where PPFP should be included or enhanced to affect national policy
29	FP Costed Implementation Plan	Government website or other publicly available citation		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:	Kenya	Country Coordinator:	

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 1:	**National Integrated Family Planning Program**

	Health System Dimension	**Strenths**	**Weaknesses**	**Opportunities**	**Threats**
I	Health Services				
	a. Public sector	Good coordination of stakeholders from National level	Service setting may not allow provision of dedicated PNC/PPFP (few staff, no space)	National FP Guidelines are undergoing review this year and there is potential to strongly incorporate PPFP	Devolution of health services has created new level of service managers that have low capacity to implement programs; Low prioriization of PPFP by county leadership
		Integrated prgram, hence possible to use funds from several "pots"		Free maternity services are an opportunity to increase facility deliveries	
		FP commodity situation has improved		Strong Immunization program	
	b. Faith-based/non-governmental organization (NGO)	Some NGO operate in areas that even public sectorhas not been able	Hish staff turnover	Have numerous primary health care facilities	Some faith based facilities have religious objections to FP
			Miss out on training/ have low skill level		
	c. Private sector	Client centred (clients prefer them even when they have poor quality)	Higher cost of services	Have numerous primary health care facilities	May miss out on FP stocks when there is shortage as they rely on Govt Supply system

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
2	Health management information system (HMIS)	Functional DHIS II System with relatively high reporting rates; PNC Tools/ MCH available in the country	No specific country indicators for PPFP,Monitoring aspects of program still weak - Low utilisation of facility data tools/ Poor documentation of PPFP especially in the integration environement; Data is not summarised and available in one place	ICD10 AND ICDMM Training are underway and is an opportunity to improve recording/reporting; Have existing PNC tools ; E-health - MCH booklet has been digitised - Country has ehealth & mhealth strategy; PMA System in country with Technical Staff seconded to MOH RMHSU	Due to devolution, tools/HMIS is not prioritised
3	Health workforce	Counties now have capacity to and have started hiring own health workers (and incentivising staff to remain within the county)	Lack of trained health workforce on PPFP methods; Few overworked staff hence no focus on screening for FP need ;		Unclear transition arrangements from central to county governments; High turnover; Strikes ; Retiring workforce after expiry of 5-year extension
4	Medicines and technology	Structures exist to govern medicines (KEMSA, PPB) ; Existence of EML ; Introduction of Sayana Press	Stock outs; weak supply chain; Weak capacity to do F&Q at county level	Costed implementation Plans ; County	No donor commitments for commodities; GOK commitment for commodities is low (Ksh 50 mill); Counties can choose not to priitise procurement of FP commodities
5	Health financing	Most PNC/PPFP services are free/cheap;	Fragmented pool of health funds at national and county level	Maternity services are now free, hence with increased delivery servcices there is opportunity to improve PPFP	Low budget lines for FP
6	Leadership and governance	Council of Governers formed with a functional Health Committee; CEC Health Committees; National Goodwill on National Level (Beyond Zero etc); Immunization and Family Planning are under one roof.	More red tape brought by devolution	Opportunities to engage Council of Governers for bulk procurments	Political - Tyranny of numbers
7	Community and sociocultural				
	a. Community-based	Have a functional community health strategy	CHVs not supported in many counties	CBD curriculum for DMPA has been approved	
		Trained CHVs	No funding to train them	Some counties have gone ahead to budget for payment of CHVs	Sustainability of county payments for CHVs
		Enabling environement - Community MNCH guidelines ; Policy on Depo in Hard to Reach areas			
	b. Mobile outreach	Able to improve access to communities	Need to be better planned and demand creation before they can be successful	Beyond Zero Integrated Outreaches	No threat for outreaches

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
7	b. Mobile outreach	RED Strategy		Malezi Bora - already geared towards maternal components	Are expensive to sustain
	c. Social marketing	Robust social marketing programs in the country	Could be expensive	Opportunity to scale up OBA, include	Low coverage
			Few products; Sometimes are stocked out and rely on governemnt stocks		

Existing PPFP Program 2:

Health System Dimension		Strenths	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				

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
7	a. Community-based				
	b. Mobile outreach				
	c. Social marketing				

Existing PPFP Program 3:

Health System Dimension		Strenths	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				

	Health System Dimension	Strenths	Weaknesses	Opportunities	Threats
7	Community and Sociocultural				
	a. Community-based				
	b. Mobile outreach				
	c. Social marketing				

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PPFP Country Programming Strategies Worksheet

Country:	Kenya	Country Coordinator:	Agnes Nakato

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:	
Revitalising Post Natal Care Services as the anchor for PPFP services	
Activity 1:	**Review of National FP Guidelines to Include new MEC and PPFP and emphasize importance of Post-Partum FP**
Timeframe	**July 2015 - 1st review: November 30th 2015**
Evidence of success	**Revised Guidelines signed by Director of Medical Services**
Total cost over timeframe	**-- Document revision - KSh 2,500,000, County Consultations - 3,000,000, Dissemination & printing - 5,000,000;**
Additional considerations	**Policies to expand method mix and choice (Contraceptives to adolescents; Sayana, PVR, ; CHV to provide more method mix & re-supply processes, PVR) County consultations and involvement in the process in view of devolution; Consensus with county governments; Review current job aids to align with guidleins**
Key stakeholders	**County Governments, UN H4+, USAID, Jhpiego, Population Council, CHAI, MSK, PSK, MSI, NCPD,**
Implementing agency(ies)	**MOH; UNFPA, [Confirm level of funding available]**
Activity 2:	**Advocacy and messaging / communication nationally and within counties on ….(on importance of PPFP, targeting adolescents, etc)**
Timeframe	
Evidence of success	
Total cost over timeframe	**Advocacy and messaging / communication nationally and within counties on ….(on importance of PPFP, targeting adolescents, etc)**

Additional considerations	Defning minium package of post partum FP services ; "Rethinking" PPFP ;
Key stakeholders	
Implementing agency(ies)	
Activity 2:	Conduct orientation of national, county and partner trainers on PPFP
Timeframe	6 months (post acceptance of plan)
Evidence of success	Prescence of oriented TOTs at National, County, and partner level
Total cost over timeframe	6-10 people per county 21%
Additional considerations	Develop an addendum to orient on PPFP to be used in LARC , PNC, PMTCT, EMONC, Nutrition, FANC trainings; Align current job aids with new MEC; Consider community component (midwives) in this revison
Key stakeholders	FP TWG members
Implementing agency(ies)	MOH
Activity 3:	Strengthening of PNC Data Management and Reporting
Timeframe	Dec-16
Evidence of success	A defined PPFP Indicator, Revised Tool (s) to capture PPFP tools, Inclusion in DHIS, Improved Reporting using PNC Register
Total cost over timeframe	
Additional considerations	Defining PPFP inficator for the country, Include guidance on capturing PPFP data in PPFP Orientation package; Including the indicator in various service delivery points, Clear guidance on reporting for PPFP services offered in different servie areas; Consider including in electronic register in facility/counties where this is happening, Tracking PPFP indicators outside DHIS to make case for revision. Generating evidence on how best to change data tools.
Key stakeholders	HMIS;
Implementing agency(ies)	
Indicator(s) (Data Source):	
Future PPFP Program 2:	
Reducing unmet need among 0 - 12 months post partum	
Activity 1:	Scaling up of Provider Initiated FP Approach in all clincial areas implementing integrated RH/FP services
Timeframe	
Evidence of success	
Total cost over timeframe	

Additional considerations	
Key stakeholders	
Implementing agency(ies)	
Activity 2:	**Adolescent Needs for PPFP**
Timeframe	
Evidence of success	
Total cost over timeframe	
Additional considerations	**Consider seeing how to put in ASRH policy**
Key stakeholders	
Implementing agency(ies)	
Activity 3:	**Include FP (including PPFP) in the Free Maternity Services package**
Timeframe	**Aug-15**
Evidence of success	**Inclusion of FP package**
Total cost over timeframe	
Additional considerations	
Key stakeholders	
Implementing agency(ies)	
Indicator(s) (Data Source):	
Future PPFP Program 3:	
Strengthening Community Post Partum FP Services	
Activity 1:	**Enabling task shifting to facilitate Community provision of selected PPFP services - (eg LAM, EC, Tracking & Referral of Clients & Messaging on PPFP;)**
Timeframe	
Evidence of success	
Total cost over timeframe	
Additional considerations	**Incorporation of PPFP in community CMNH package + Incorporating in CHV FP Curriculum**
Key stakeholders	**Community Health Strategy Department**
Implementing agency(ies)	
Activity 2:	
Timeframe	
Evidence of success	

Total cost over timeframe	
Additional considerations	
Key stakeholders	
Implementing agency(ies)	
Activity 3:	**Incorporation of PPFP into Baby Friendly Community Inatiative**
Timeframe	
Evidence of success	
Total cost over timeframe	
Additional considerations	
Key stakeholders	
Implementing agency(ies)	
Activity 4:	**Community Efforts to improve facility utilisation for delivery services**
Timeframe	
Evidence of success	
Total cost over timeframe	
Additional considerations	**Linked to free maternity program ; Link with Malezii bora activities**
Key stakeholders	
Implementing agency(ies)	
Activity 4:	**Male Involvement during ceremonies (to rethubk further)**
Timeframe	
Evidence of success	
Total cost over timeframe	
Additional considerations	**Information to the man ?**
Key stakeholders	
Implementing agency(ies)	
Indicator(s) (Data Source):	

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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?			
12	Have the activities for implementing the program been kept as simple as possible without jeopardizing outcomes?			

	Scale-up Consideration	Yes	No	More Information/Action Needed
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?			
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?			

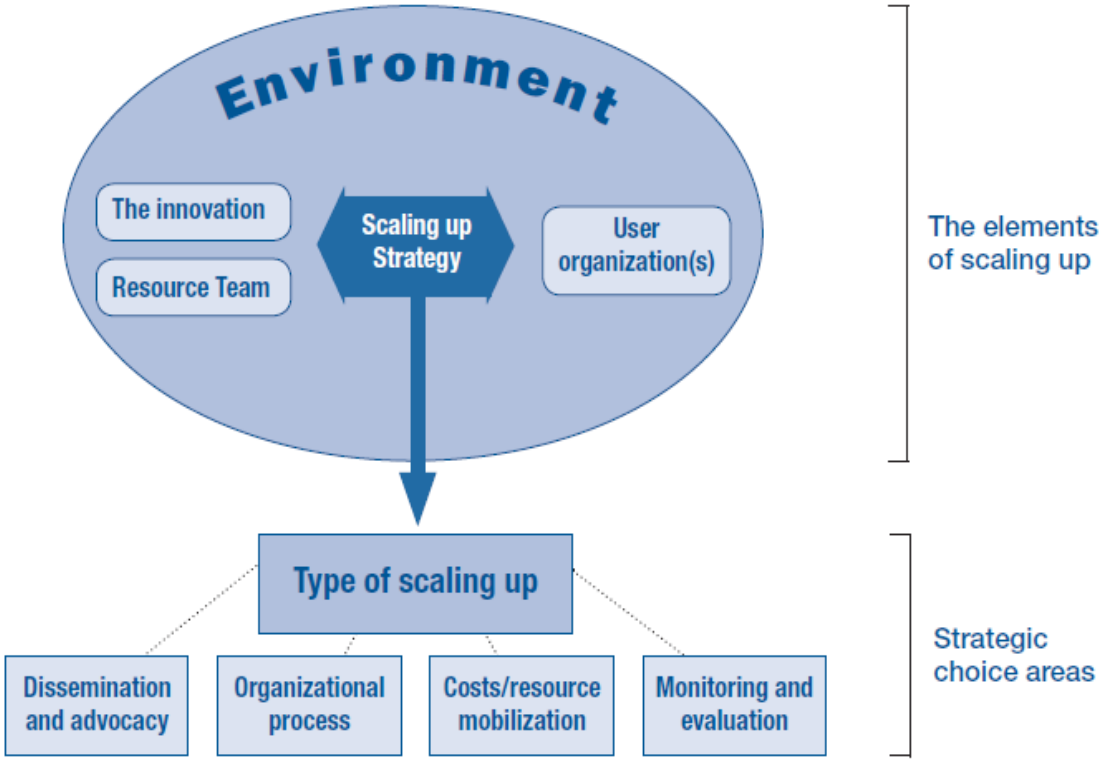
	Scale-up Consideration	Yes	No	More Information/Action Needed
5	Is the program based on sound evidence and preferable to alternative approaches?			
6	Given its financial and human resource requirements, is the program feasible in the local settings where it is to be implemented?			
7	Is the program consistent 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?			
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?			
	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?			
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?			

	Scale-up Consideration	Yes	No	More Information/Action Needed
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?			
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?			

	Scale-up Consideration	Yes	No	More Information/Action Needed
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:	Kenya	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	Sharing with wider stakeholders County PPFP plan				
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					