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.

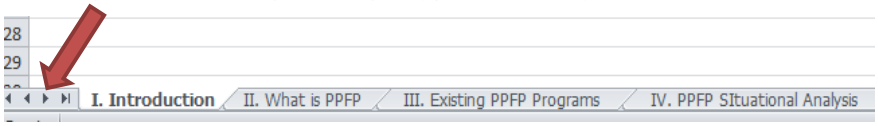
(4) For each of the future PPFP programs, complete a detailed PPFP Implementation Plan and consider how each program can best be scaled up to reach national and global family planning goals.

(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]

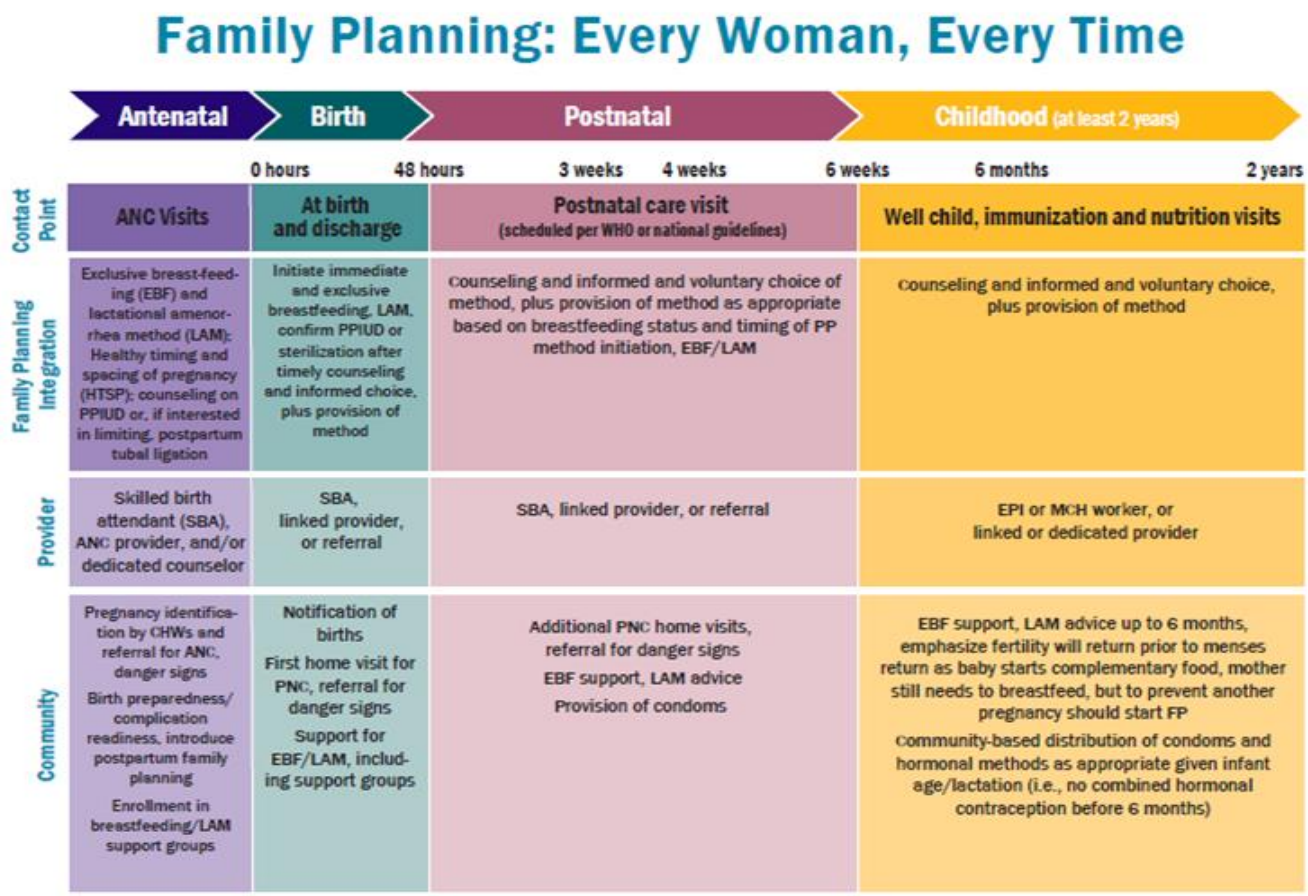
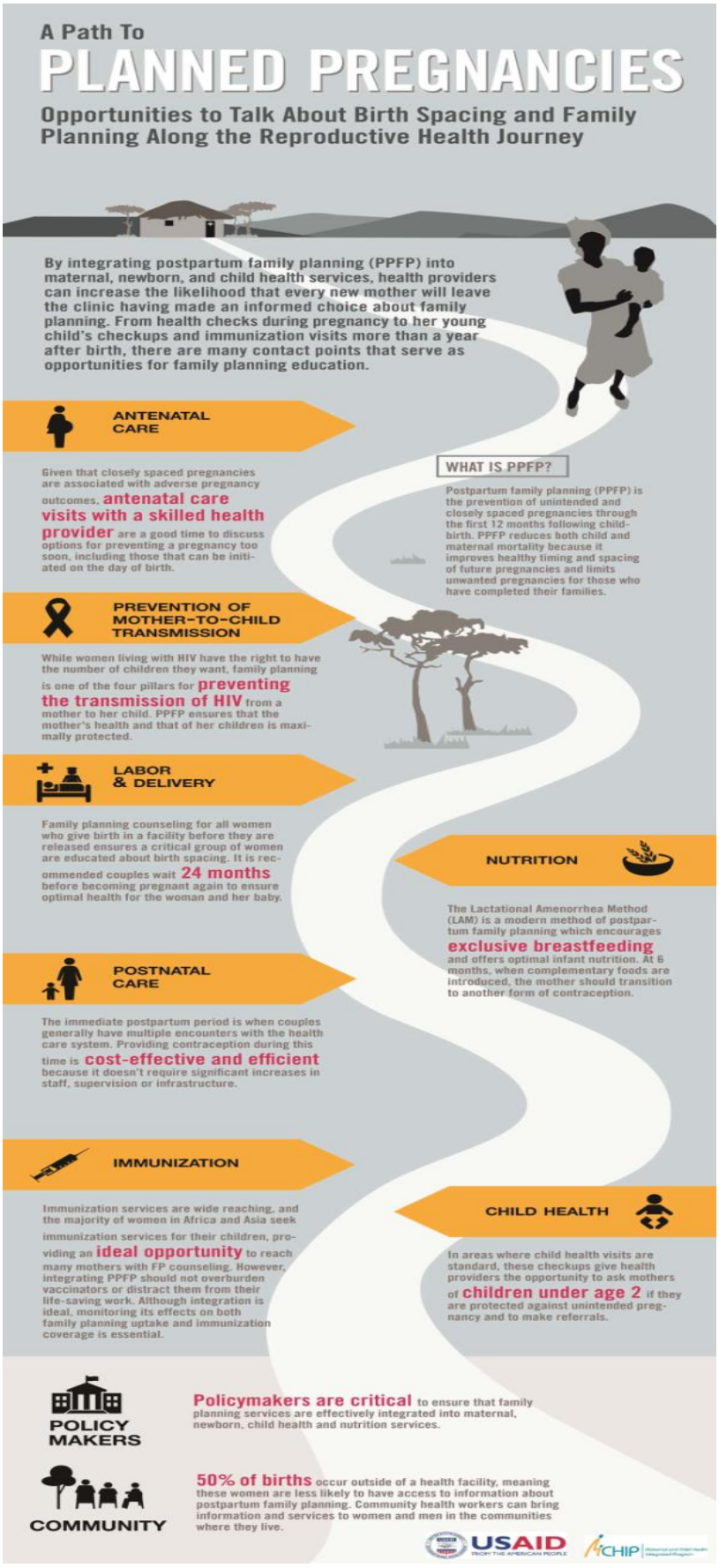


Figure 2. PPFP Integration Opportunities [MCHIP 2013]



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Country:	Ethiopia	Country Coordinator:	Tigist Worku

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:	**Strengthen awaerness of and demand for PPFP during the ANC period**
Activity 1:	**Integration of PPFP information and counseling with ANC & PMTCT services offered at facility and community levles**
Timeframe	**For ANC it was almost the past three decades, for PMTCT it is only after 2005**
Evidence of success	**Improvement seen in the quality of ANC services and PPFP use has relatively inclreased over time**
Total cost over timeframe	**Since services are provided with an integrated approach, specific cost calculation is very difficult**
Has this activity been scaled? Why or why not?	**It has been scaled as the # of facilities increased.**
Key stakeholders	**Government, public facilities, partner organizations (local and INGOs), Private sector (private-fpr profit, social franchising)**
Implementing agency(ies)	**Public and private facilities**
Activity 2:	**Assign health workers to routienly provide group education on PPFP, HTSP & EBF during ANC sessions**
Timeframe	**Over the past 2-3 decades**
Evidence of success	**Knowledge and practice has increased overtime as evedenced by DHS data**
Total cost over timeframe	**Since services are provided with an integrated approach, specific cost calculation is very difficult**
Has this activity been scaled? Why or why not?	**Yes, it is being given in every facility in the country**
Key stakeholders	**Government, public facilities, partner organizations (local and INGOs), Private sector**
Implementing agency(ies)	**Public and private facilities**
Activity 3:	**Make IEC materials on PPFP?? Avaliable at facilities(PPFP intgrated in the existing IEC materials E.g FP and ANC posters)**
Timeframe	**The past ten years**
Evidence of success	**The availability of the translated decision making tool flip charts for Family planning in facilities**
Total cost over timeframe	
Has this activity been scaled? Why or why not?	**Material preparation and distribution was done once- resource requirments may affected its scale up**
Key stakeholders	**Government, public facilities, partner organizations (local and INGOs), Donors**
Implementing agency(ies)	**Public facilities**
Indicator(s) (Data Source):	**Number of women who get PPFP counsleing during ANC visits**

Existing PPFP Program 2:	**Labour and delivery/pre-discharge**
Activity 1:	**Ensure pre-discharge counseling includes danger signes for mothers and infants, EBF, LAM**
Timeframe	**For the past 5-7 years**
Evidence of success	**Skilled birth attendant increased**
Total cost over timeframe	**Specific cost calculation is a bit difficult**
Has this activity been scaled? Why or why not?	**Yes, as a quality service indicator, its scaled as the # of providers and health facilities increased**
Key stakeholders	**Government, public facilities, partner organizations (local and INGOs), Donors**
Implementing agency(ies)	**Public facilities**
Activity 2:	**Conduct competency based counseling and clincial skills inservice training**
Timeframe	**For the past 5-7 years**
Evidence of success	**quality of services improved and # of providers providing the service with confidence increased**
Total cost over timeframe	**Not calculated**
Has this activity been scaled? Why or why not?	**Yes, as it improves the quality of services**
Key stakeholders	**Government, public facilities, partner organizations (local and INGOs), Donors**
Implementing agency(ies)	**Public facilities**
Activity 3:	**Introduce or strengthen supevision to support [providers inlcuding providing routine feedback and updates**
Timeframe	**Very recent activity**
Evidence of success	**accountability and responsibility of woreda and zonal RH officers increased**
Total cost over timeframe	**Not calculated**
Has this activity been scaled? Why or why not?	**Yes, b/c the governemtne is now on fullboard to lead the supportive supervision and feedback**
Key stakeholders	**Government, public facilities, partner organizations (local and INGOs), Donors**
Implementing agency(ies)	**Public facilities**
Indicator(s) (Data Source):	**# of clincial staff trained to competency in PPFP counseling and PPIUCD and/or PPTO services; number of inservice curricula that include clinical skills for PPIUCD and PPTO serices**
Existing PPFP Program 3:	**Infant health and immunization services/PNC**
Activity 1:	**Immunization providers screen women about their FP needs and give a voucher or referral card for FP services????**
Timeframe	**in the past 2-3 decades**
Evidence of success	**CPR increased**
Total cost over timeframe	**Not calculated**
Has this activity been scaled? Why or why not?	**yes as the CPR increased with**
Key stakeholders	**Government, public facilities, partner organizations (local and INGOs), Donors**
Implementing agency(ies)	**Public facilities**
Activity 2:	**Dedicated FP provider offers co-located FP services, including LARCs, the same day before mother returns home**
Timeframe	**for the past decade**

Evidence of success	**Utilization of LARCs showen an increase**
Total cost over timeframe	**Not calculated**
Has this activity been scaled? Why or why not?	**yes**
Key stakeholders	**Government, public facilities, partner organizations (local and INGOs), Donors**
Implementing agency(ies)	**Public facilities**
Activity 3:	**Community based workers (HEWs) mobilize mothers for immunization days and assist with/participate in FP group education sessions, and follow up mothers in the household for FP**
Timeframe	**Past decayed**
Evidence of success	**PPFP and CPR in general increased**
Total cost over timeframe	**Not calculated**
Has this activity been scaled? Why or why not?	**yes**
Key stakeholders	**Government, public facilities, partner organizations (local and INGOs), Donors**
Implementing agency(ies)	**Public facilities**
Indicator(s) (Data Source):	**Propotion of Facilities offering at least three FP methods incluing LAM; number/percentage of women who strated contraceptive use by 6 weeks postpartum**

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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)	90,076,012	Population that will benefit from families reaching desired size
2	Annual population growth, %	Population Reference Bureau "Rate of Natural Increase" (see Tab IX)	2.44	Pace of population change that could be slowed with PPFP
3	Crude birth rate	Population Reference Bureau (see Tab IX)	28	Numbers of births occurring
4	Number of women of reproductive age (WRA)	Population Reference Bureau (see Tab IX)	20,086,950 (22.3% of the total population)	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)	1,004,347 (5% of WRA)	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)	4.1	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)	4	Compare with #6 on total fertility rate
8	Adolescent fertility rate	Population Reference Bureau (see Tab IX)	46 births /1000 adolescents 15-19 years	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)	9, 12,36,23	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.)

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
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)	1,0,19.6,20	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)	25.3	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 16.3 and Limiting 9	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	74	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)	41.8	Population of women who are currently using family planning
15	Your country's CPR target	Government website or other publicly available reference	55	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)	33.9,6.1,0,0.1 and other 0.3 traditional 1.4	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)	40	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)	0-6 months = 52% (DHS 2011) 0-1months= 70.3%, 4-5 moths=31.8%	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.

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
19	Percentage of deliveries in health facilities	Demographic and Health Survey (see Tab IX)	15.4	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)	83.8	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	12	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	10,3, and 3days-41 days 5	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)	BCG= 65.2%, DPT1= 62.2%, DPT3= 34.7% (DHS 2011), ASK MOH FOR THE DROPOUT RATE	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	No widescale data but from limited studies-32%	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]	14% (Regional figure), Ethiopia 23/1000 data from Guttamer Institute	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

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
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:	Ethiopia	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:	**Strengthen awaerness of and demand for PPFP during the ANC period**

	Health System Dimension	**Strenths**	**Weaknesses**	**Opportunities**	**Threats**
I	Health Services				
	a. Public sector	Health workers are trained on provision of FP couseling	Lack of internal linkages and referals among MNCH SDPs	avalibility national RH, AYSRH strategy and FP guideline	
		FP/RH and MNCH services organzied with in the same unit	Limited utilization of job aids and more focus on non-FP issues during ANC	FP is Government priority area and part of its Growth and Transformation Plan (GTP)	
		Health Education on individual bases and in groups is given	LARCs is not well adressed and limited competency trainign for PP LARC methods	Partner organizations existance, Expansion of health facilities including health posts at village level minimizing distance to services	
	b. Faith-based/non-governmental organization (NGO)	resource mobilzation for training and coaching and mentoring and material production	limited project implementation time and geographical area coverage	Avaialability of Donor support to the NGO sector	
		advocates for and work on Integration of services	limited capacity building activities on coaching and mentoring	Political commitment for GOE in the inclusion of non-Governement actors in the health service	
	b. Faith-based/non-governmental organization (NGO)	uses latest developmnets to improve quality service delviery	High turnover of skilled human resources	The existence of other development acticites by NGOs to integrate health services	
	c. Private sector	Provide ANC	poor integration of services	An increase in number of private sector facilities with interest to provide MNCH services	
		Have adequateinfrastructure at maernity SDPs	FP/RH and MNCH services are provided indifferent units	Existence of policy for involving the private sector	
		Work on IEC/BCC	High cost for services and limited mechanism of catering the poor	Significal number of deliveries happening at private sector creating a conducive environment for PPFP	

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
2	Health management information system (HMIS)	FP is tracked as one indicator	some PPFP indicators can not be tracked from the HMIS reporting formats, since they are not included in the reporting formats	At SDP providers can use the register to do analysis on PPFP; periodical reviewes of HMIS can be used to influence the importance of PPFP data inclusion	
3	Health workforce	Trained on counseling and providing some of the short term FP methods	Limited skill and knowledge on PPIUCD counseling and insertion; Separate FP unit created a gap for continuty of services; Limited capacity of community level workers like HEWs on PPFP/ no standard PPFP messages used by HEWs	National level FP guidelines and protocols; An increased emphasis by MOH in the introduction of LARC as PPFP methods; skilled delivery at facility level increased significantly over the past 2 years	
4	Medicines and technology	integrated system for procurment and supply of MNCH/FP commodities exisit;	shortage of commodities, equipments and supplies at SDPs at all levels; weak integrated service deleivery setings such as L&D, immunization		
5	Health financing	FP services are part of basic services; a separte budget exisit for FP	No separate budget allocated for PPFP services and commodities;	Natiional RH costing exercise done which includes FP programs	
6	Leadership and governance	National FP stnadards, guidelines and protocols exisit	guidelines and standards are not avalibile at facility level for providers; limited orientation given on exisitng guidelines	Partners and health offices to support midlevel staff to provide PPFP services	
7	Community and sociocultural				
	a. Community-based	Existance of community level structure e.g. HEWs, HAD, to counsel and teach mothers	low awearness of the community and health workers on retun to fertility, return to sexual activity etc..;	BF is practicied by large # of the community	
		Availability of family health card at household level	Low male invovement	Homevisits by HEWs after delivery	

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
7	b. Mobile outreach	Its part of health facilities task to do outreach services	Not organzied, and no standard; not measureable; mailny focuses on Immunization activities	PHCU linkage (Health Center to Health post)	
	c. Social marketing	Available commodities for PPFP through social marketing (DKT through private pharmacies)	Cost of commodities for the poor not affordable	Increased number of outlets	
		Easy access through private drug outlets	Brand specific advertisments	use of media	
		Use media to create awareness			
Existing PPFP Program 2:		**Labour and delivery/pre-discharge**			
Health System Dimension		**Strenths**	**Weaknesses**	**Opportunities**	**Threats**
1	Health Services				
	a. Public sector	trained midwivevs provide services	lack of some consumable PPFP supplies		
			providers focuses only on delivery services	Government planned scale up of PPIUCD serivices	
			poor integration of services with other SDPs		
	b. Faith-based/NGO	Initiated PPFP/PPIUCD services in some facilities	low area coverage due to budget constraint	Commitment from GOE and donors to scale up PPFP/PPIUCD services	
		Integration of PPIUCD with ANC, L&D service points	no standardized mentorship/coaching		
		Collaborate with FMoH in adopting training packages, and actively participate in provision of basic trainings; provision of necessary equipments and supplies			
	c. Private sector				
2	HMIS		HMIS do not capturePPFP/PPIUCD indicators		
3	Health workforce	Serivce provided by trained providers- inservice training	low commitment from providers; poor utilization of jobaids in their day to day work	FMoH planned for scale up and sustainability	

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
4	Medicines and technology	Integrated system of procurment and supply of PPIUCD			
5	Health financing				
6	Leadership and governance				
7	Community and Sociocultural				
	a. Community-based	Awearness increased for facility based delivery services	Still some socio cultural barriers that prevent mothers to come for facility based delviery		Low skilled birth attendance
			inaccessibility of some facilities due to geographical location		
	b. Mobile outreach				
	c. Social marketing				

Existing PPFP Program 3:	Infant health and immunization service/PNC??

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
1	Health Services				
	a. Public sector	Immunization providers provide FP infomration and link for services	poor quality of FP counseling, no mechanism exisit to track motehrs referred for FP		
		Immunization providers provide FP services	counseling foucs on short term FP methods	esitance of HEWs and HDAs at community level	
		HEWs provide immunization and short term FP services at community level	lack of standards, job aids to transmit messages on FP		
	b. Faith-based/NGO	Support the strengthening of integration b/n immunization and FP services	integration of services not scaled up		
	b. Faith-based/NGO				
	c. Private sector				

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
2	HMIS		do not capture the intgerated services (FP/immunization)		
3	Health workforce	trained providers provide both immunization and FP services	Mainly focus on immunization		
4	Medicines and technology				
5	Health financing				
6	Leadership and governance	both immunization and FP trainings are integrated in preservice education			
7	Community and Sociocultural				
	a. Community-based	High acceptance of immunization services by the community	poor male involvement		
	b. Mobile outreach	Immunization and short term FP methods provided during outreach programs			
	c. Social marketing				

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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:	
Activity 1:	**Integration of PPFP information and counseling with ANC & PMTCT services offered at facility and community levles**
Timeframe	**Immidate 2016 /medium 2016-2020**
Evidence of success	**Persence of intrafacilities referal linkage ,Reciveing of counseling for PPFP at ANC,and Capturing Data for PPFP at ANC??**
Total cost over timeframe	**Estimate costs of FP TWG time ,FP stamp ,ANC registeration Book,Client card ,referal slip and orentation /update**
Additional considerations	**Using FP choice stamp,Intrafacilities Referal slip,Revising ANC Regsiteration book & client card**
Key stakeholders	**MOH,RHB ,Implimenting partneres and Doners**
Implementing agency(ies)	**MOH ,partneres and Doners**
Activity 2:	**Assign health workers to routienly provide group education on PPFP, HTSP & EBF during ANC sessions**
Timeframe	**Immidate 2016 /medium 2016-2020**
Evidence of success	**Health education registers PPFP topics clearly included in ANC health education,Knowledge of PPFP improved on ANC**
Total cost over timeframe	**Estimate costs of standerdized health education register**
Additional considerations	**Orentation**
Key stakeholders	**MOH,RHB ,Implimenting partneres and Doners**
Implementing agency(ies)	**MOH ,partneres and Doners**
Activity 3:	**Revise Family health card to incorporate PPFP messages**
Timeframe	**Immidate 2016 /medium 2016-2020**

Evidence of success	Avaliblity and use of supervision data
Total cost over timeframe	Estimate costs of supervision,family health card revision and FP TWG ,RHB orentaion
Additional considerations	using local mediaand harmonization of electrnic media messages
Key stakeholders	MOH,RHB ,Implimenting partneres and Doners
Implementing agency(ies)	MOH ,partneres and Doners
Indicator(s) (Data Source):	% of women reciveing counsling during ANC, % of session provided during ANC,% stamp card ??
Future PPFP Program 2:	
Activity 1:	Ensure pre-discharge counseling on intgrated Maternal neaborn services including PPFP
Timeframe	Immidate 2016 /medium 2016-2020
Evidence of success	Increase PPFP users at discharage
Total cost over timeframe	Estimate costs of Whole site orentaion,Revising ANC Regsiteration book & client card
Additional considerations	Whole site Orentaion ,Revising Laor & delivery Regsiteration book ,standirdazation of PPFP register in Labour& delivery register & client card
Key stakeholders	MOH,RHB ,Implimenting partneres,Professional associations ,Doners,Public and private Health facilities
Implementing agency(ies)	MOH and partneres (FP TWG)
Activity 2:	Conduct competency based counseling and clincial skills inservice training
Timeframe	Immidate 2016 /medium 2016-2020
Evidence of success	Increased number of competent health care workers to provide PPFP services and periodic users satisifaction
Total cost over timeframe	Estimate policy,carriculum,training materials and job aids revision costs,training cost,post training follow up ,mentor and training evaluation cost
Additional considerations	Post training follow up ,mentoring and structured on the job training,revising policy,curriculum,training materials and job aids
Key stakeholders	MOH,RHB ,Implimenting partneres,Professional associations ,Doners,Public and private Health facilities
Implementing agency(ies)	MOH and partneres (FP TWG)
Activity 3:	Introduce or strengthen supevision to support [providers inlcuding providing routine feedback and updates
Timeframe	Immidate 2016 /medium 2016-2020
Evidence of success	Post training follow up ,mentoring conducted as planned ,existance of written feedback and sustaened service provision
Total cost over timeframe	Estimate post training follow up ,mentor , training evaluation cost and cheiklist revision cost
Additional considerations	cheiklist revision and mentorshipguide perparation
Key stakeholders	MOH,RHB ,Implimenting partneres,Professional associations ,Doners,Public and private Health facilities

Implementing agency(ies)	MOH and partneres (FP TWG)
Indicator(s) (Data Source):	%of women recived counsling predischarge,% of women provided with PPFP methods,
Future PPFP Program 3:	
Activity 1:	Immunization providers screen women about their FP needs and give a voucher or referral card for FP services.
Timeframe	Immidate 2016 /medium 2016-2020
Evidence of success	Persence of intrafacilities referal linkage ,Reciveing of counseling for PPFP at Immunization,and Capturing Data for PPFP at Immunization
Total cost over timeframe	Estimate costs of FP TWG time ,Immunization registeration Book,Client card ,referal slip and orentation /update
Additional considerations	Intrafacilities Referal slip,Revising Immunization Regsiteration book & client card
Key stakeholders	MOH,RHB ,Implimenting partneres,Professional associations ,Doners,Public and private Health facilities
Implementing agency(ies)	MOH and partneres (FP TWG)
Activity 2:	PPFP services provided same daysame day at Immunization SDPs
Timeframe	Immidate 2016 /medium 2016-2020
Evidence of success	Persence of intrafacilities referal linkage ,Reciveing of counseling for PPFP at Immunization,and Capturing Data for PPFP at Immunization
Total cost over timeframe	Estimate costs of FP TWG time ,Immunization registeration Book,Client card ,referal slip and orentation /update
Additional considerations	Intrafacilities Referal slip,Revising Immunization Regsiteration book & client card
Key stakeholders	MOH,RHB ,Implimenting partneres,Professional associations ,Doners,Public and private Health facilities
Implementing agency(ies)	MOH and partneres (FP TWG)
Activity 3:	Community based workers (HEWs & HDAs) mobilize mothers for immunization days and assist with/participate in FP group education sessions, and follow up mothers in the household for FP
Timeframe	Immidate 2016 /medium 2016-2020
Evidence of success	Persence of out reach registration format,increased number of reciving counseling for PPFP at Immunization,and Capturing Data for PPFP at Immunization
Total cost over timeframe	Estimate costs of FP TWG time ,out reach Immunization registeration format and orentation /update
Additional considerations	Revising out reach Immunization Regsiteration format
Key stakeholders	MOH,RHB ,Implimenting partneres,Professional associations ,Doners,Public and private Health facilities
Implementing agency(ies)	MOH and partneres (FP TWG)
Indicator(s) (Data Source):	Propotion of Facilities offering at least three FP methods incluing LAM; number/percentage of women who strated and /or continued contraceptive use by 6 weeks postpartum

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

PPFP Country Programming Strategies Worksheet

Country:	Ethiopia	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?			
2	Are individuals from the implementing agency(ies) involved in the program's design and implementation?			

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

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

	Scale-up Consideration	Yes	No	More Information/Action Needed
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?			
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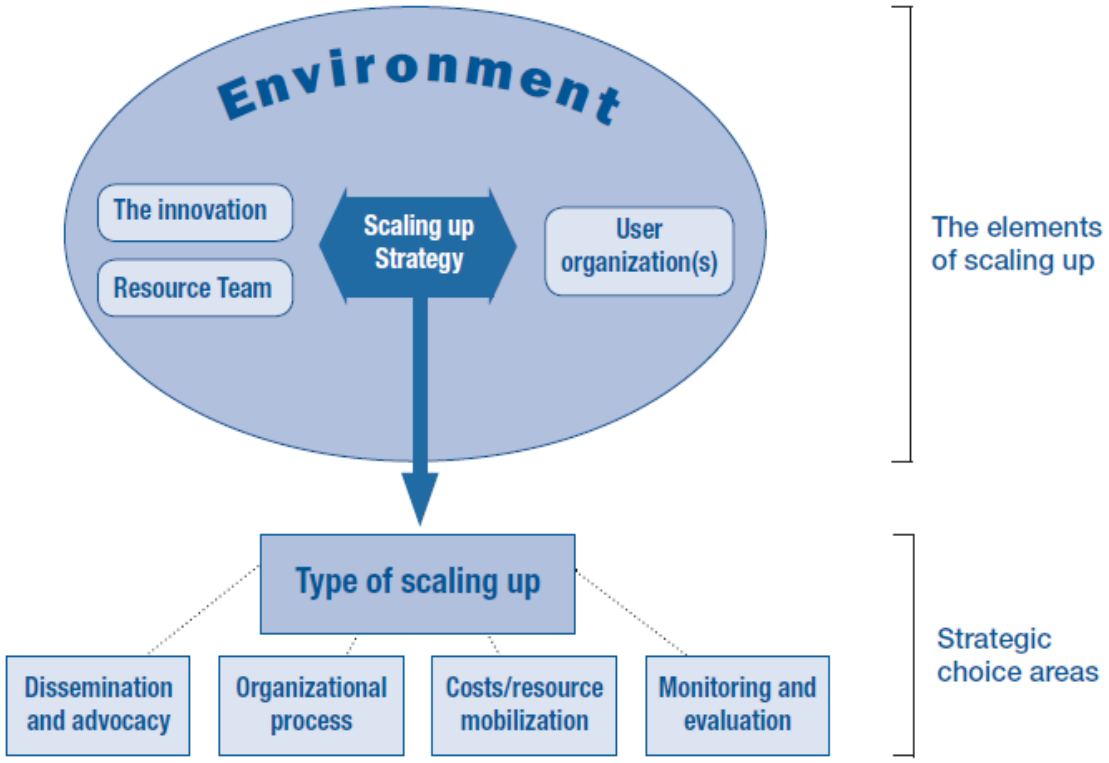
17	Does the health system currently have the capacity to implement the program? If not, are there plans to test ways to increase health-systems capacity?			
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?			
19	Is there provision for 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]



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

PPFP Country Programming Strategies Worksheet

Country:	Ethiopia	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					