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.

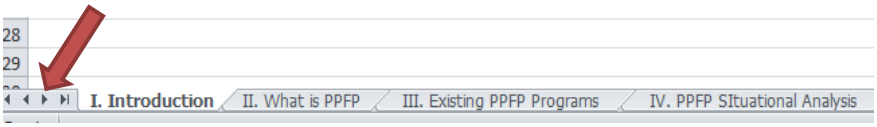
(4) For each of the future PPFP programs, complete a detailed PPFP Implementation Plan and consider how each program can best be scaled up to reach national and global family planning goals.

(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]

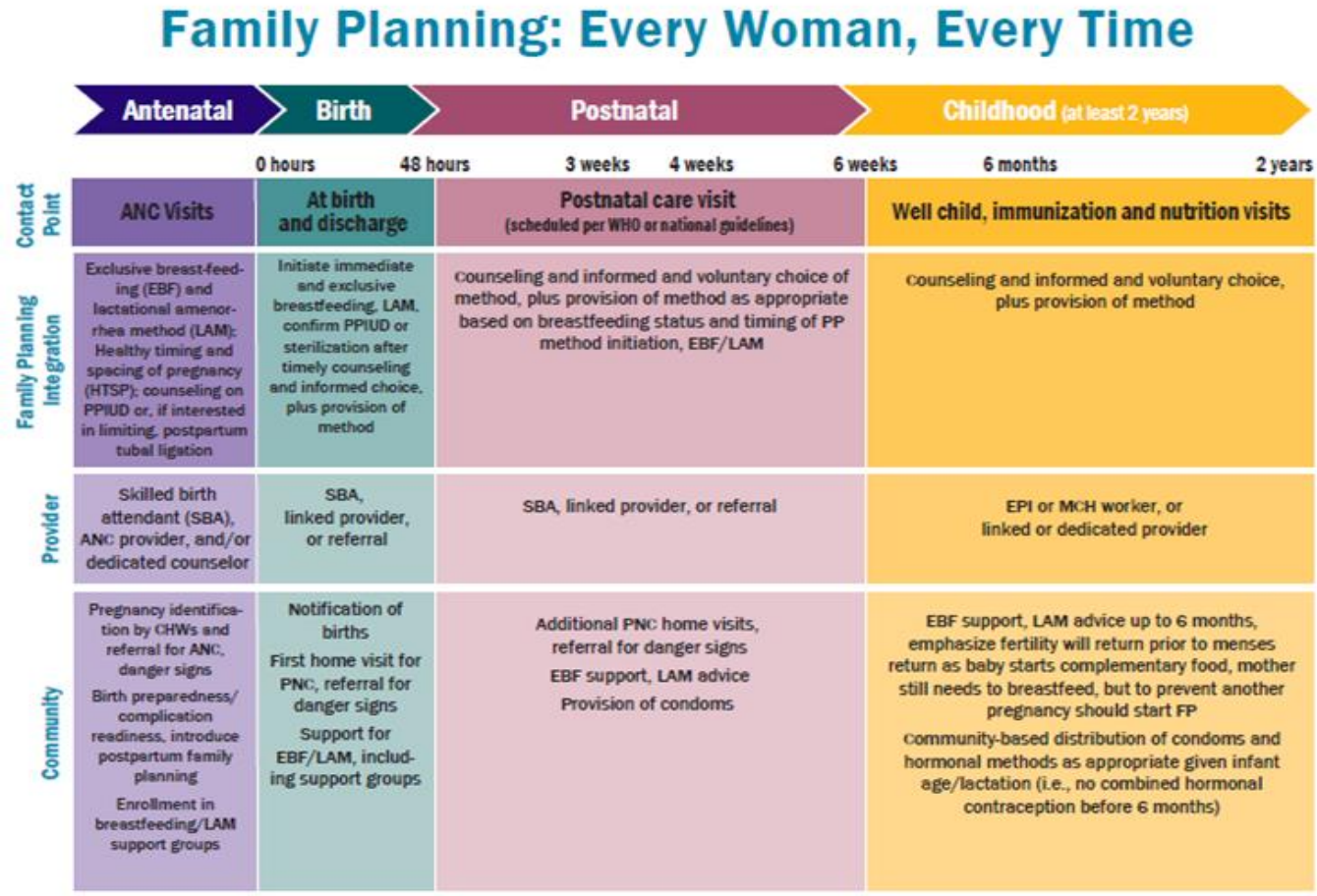
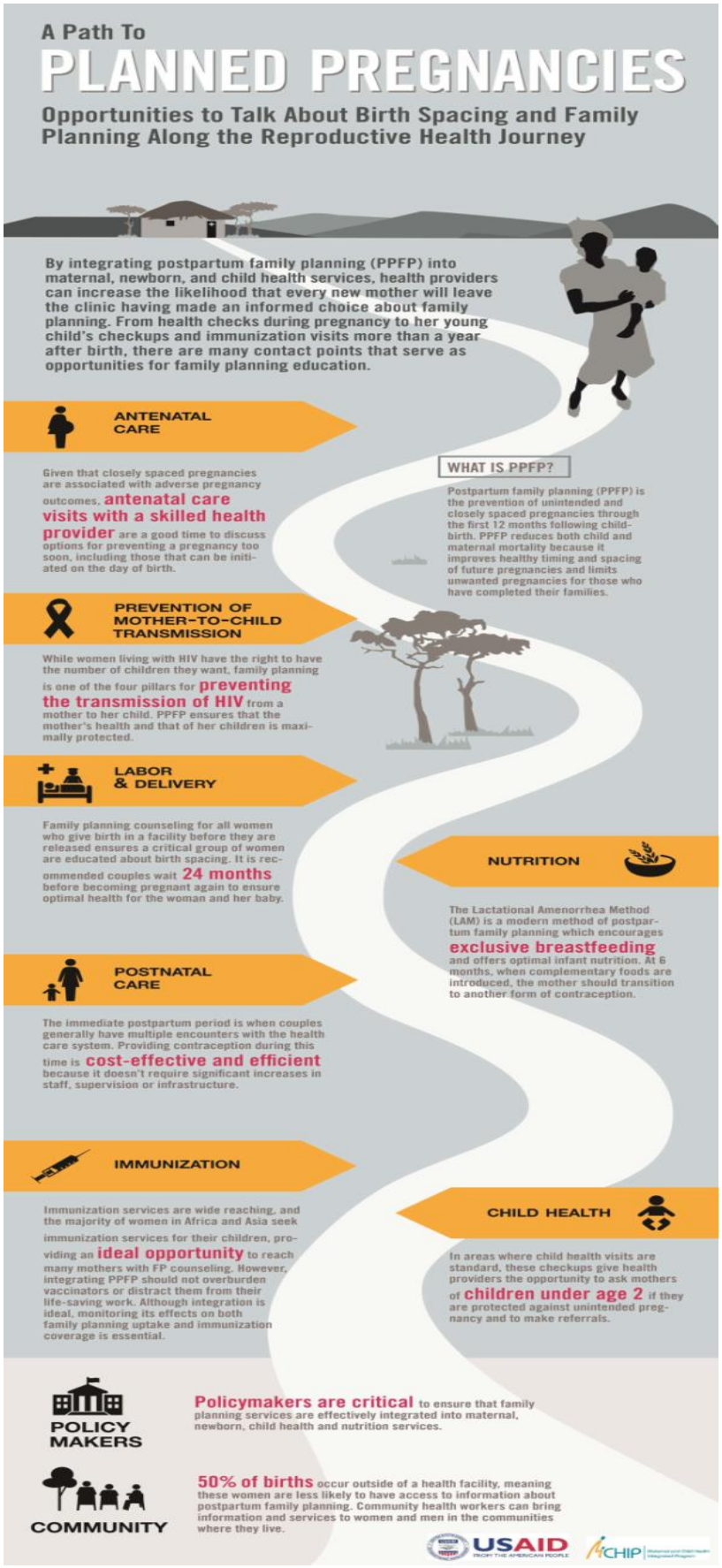


Figure 2. PPFP Integration Opportunities [MCHIP 2013]



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Country:	Nigeria	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:	**Integrating PPFP with MNH/EmONC services**
Activity 1:	**Inproving PPFP services**
Timeframe	**2006-2009**
Evidence of success	
Total cost over timeframe	
Has this activity been scaled? Why or why not?	**Yes, because of its positive results it was scaled up to another state in the North West**
Key stakeholders	**Health care worker at ANC, Labour and delivery wards,Postnatal Wards, Post natal clinics, Immunization units, child welfare clinics, FP coordinators, Facility managers**
Implementing agency(ies)	**State Ministry of Health, Jhpiego Nigeria**
Activity 2:	**Increasing demand for PPFP at Household level**
Timeframe	**2006-2009**
Evidence of success	
Total cost over timeframe	
Has this activity been scaled? Why or why not?	**Yes, because of its positive results it was scaled up to another state in the North West**
Key stakeholders	**Health care worker at ANC, Labour and delivery wards,Postnatal Wards, Post natal clinics, Immunization units, child welfare clinics, FP coordinators, Facility managers, Community through the WDCs and VDCs**
Implementing agency(ies)	**State Ministry of Health, Jhpiego Nigeria**
Activity 3:	**Creating a supportive environment at the community level**
Timeframe	**2006-2009**
Evidence of success	
Total cost over timeframe	

Has this activity been scaled? Why or why not?	Yes, because of its positive results it was scaled up to another state in the North West
Key stakeholders	Health careworkers at CAN, Labor and delivery units, postnatal wards, immunization units, child welfare clinics, FP coordinators, facility managers, commnity members through the WDCs and VDCs
Implementing agency(ies)	State Ministry of Health, Jhpiego Nigeria
Indicator(s) (Data Source):	
Existing PPFP Program 2:	
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):	
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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PPFP Country Programming Strategies Worksheet

Country:	Nigeria	Country Coordinator:	Dr Kayode Afolabi

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)	177,500,000	Population that will benefit from families reaching desired size
2	Annual population growth, %	Population Reference Bureau "Rate of Natural Increase" (see Tab IX)	2.47	Pace of population change that could be slowed with PPFP
3	Crude birth rate	Population Reference Bureau (see Tab IX)	39/1000	Numbers of births occurring
4	Number of women of reproductive age (WRA)	Population Reference Bureau (see Tab IX)	39,100,000	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)	6,924,138	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)	5.6 PRB 2014	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)	7.1	Compare with #6 on total fertility rate
8	Adolescent fertility rate	Population Reference Bureau (see Tab IX)	22.5% of women aged 15-19 have began child bearing	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)	6.9%, 16.3%, 39.1%, 19.8%,	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)	15-19 years: 12.2% 20-23 years: 23.5% 24-29 years : 25.3% 30-34 years: 23.4%	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)	16% for all married women	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: 12% Limiting: 4%	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
14	Contraceptive prevalence rate	Demographic and Health Survey (see Tab IX)	15% for morden methods (DHS 2013)	Population of women who are currently using family planning
15	Your country's CPR target	Government website or other publicly available reference	36% (by the year 2018)	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: 7.5% LARC: 1.5% LAM: 0.4% Permanent methods: 0.3%	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)	18% (DHS2013)	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)	17% under six months , 10% 4-5 months (DHS 2013)	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)	36%	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)	63%	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	40% (DHS 2013)	Population that can be reached after birth with PPFP counseling and services other than at routine immunization visits

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
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	0-23 hours: 35.9% 1-2 days: 3.8% 3-6 days: 0.6% 7-41 days: 1.2% >42 days: NA (based on 2013 DHS)	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: 51.2% DPT1: 50.6% DPT3: 38.2% Drop-out rate: 12.4%	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	25% (DHS 2013)	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	$8.35m annually for 4 years to provide free FP commodities	Country-level, public financial commitment to invest in FP
27	Statement for Collective Action for PPFP Country Endorsement	http://www.mchip.net/actionppfp/	Programs should pririotize reaching postpartum women, the group of women with the greatest unmet needs for FP in their strategic and operational plans and budget including updating the knowledge and skills of a range of providers offering a range of intergrated PPFP services in facilities and communities and ensuring that a broad range of contraceptives options are available to women, men and couples	Country-level, public support/champions for PPFP

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
28	National FP Strategy	Government website or other publicly available citation	Increase the level of modern contraceptive use among all sexually active individuals and couples from 9.8% to 36% by 2018	Where PPFP should be included or enhanced to affect national policy
29	FP Costed Implementation Plan	Government website or other publicly available citation	$33m over 4 years	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	In October 2014, GoN approved a task shifting policy for Nigeria which has provisions for training CHEWs to provide LARC services	

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Country:	Nigeria	Country Coordinator:	Dr Kayode Afolabi

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:	

	Health System Dimension	**Strenths**	**Weaknesses**	**Opportunities**	**Threats**
I	Health Services				
	a. Public sector	Large number of clients	Shortage of skilled providers	Availability of FP policy blueprint	Under the table user fee
		Free FP commodity policy	Lack of basic FP equipments in some health facilities	MSS and SURE-P programs with trained midwives and CHEWs	Religious, Traditional and sometimes political opposition to FP
		Large number of facilites	Lack of consumable supplies	ACT which provides funding for health insurance	Women's organization opposed to contraception
	b. Faith-based/non-governmental organization (NGO)	Large number of clients	Poor salary remuneration	Lack of FP equipment except for natural FP methods	Religious opposition to FP
			Inadequate human resource		Some radical groups in the North linked FP to polio immunization
	c. Private sector	Large patronage especially to patent medicine vendors	Limited number of human resource	Supporting programs that target private sector	High user fee limit client patronage for some services
		Available through social marketting	Lack of FP skills and equipment for long-acting-reversible contraception	Providing information and services nation wide	Commodity loss through pilfering and poor storage
		Promt attention, reduced waiting time			

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
2	Health management information system (HMIS)	Increasing interest in have one M&E system nationally; revised HMIS strategy in place	Weak collaboration between different levels of government; low reporting rate at sub-national level	New web-based DHIS2 which allows for direct upload form health facilities	Irregular electric supply; inadequate numbers of mobile devices for the number of health facilities
3	Health workforce	Dr, Nurses, Midwives and CHEWs	Inadequate distribution of skilled providers	Recently approved national task-shifting policy	Especially in Northern Nigeria and Southeast?Southsouth Nigeria
4	Medicines and technology	Includes some contraceptive methods	Low computer and Smartphones technology litracy	Making use of phone devices feasible	Poor electric supply to charge smartphones; limited telephone network in some areas
5	Health financing	Free FP commodity policy; National Health ACT	Poor implementation of national policies	National Health ACT, Free FP policy	Reducing price of crude oil Globally has reduced GoN revenue by more than 50%
6	Leadership and governance	Appropriate leadership for FP	Levels except in Lagos and Ogun states	Calling attention to population contral	Donor dependancy
7	Community and sociocultural				
	a. Community-based	Government and many WDCs	Poor organization of community coalitions	Salaried CHEWs available all over the country; can be trained	Demand for payment of volunteers
		There are many CSOs	Program based on volunteerism		Political interference with successful community initiatives
	b. Mobile outreach				
	c. Social marketing				

Existing PPFP Program 2:					
Health System Dimension		**Strenths**	**Weaknesses**	**Opportunities**	**Threats**

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				
	b. Mobile outreach				
	c. Social marketing				
Existing PPFP Program 3:					
Health System Dimension		**Strenths**	**Weaknesses**	**Opportunities**	**Threats**

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				
	b. Mobile outreach				
	c. Social marketing				

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Country:	Nigeria	Country Coordinator:	Dr Kayode Afolabi

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:	
Increase awareness during ANC	
Activity 1:	**Include PPFP information into the health talk during ANC**
Timeframe	**2015-2018**
Evidence of success	**Numbder/Parcentage of ANC sessions that include PPFP information and counseling. Number/percentage of women who received information about PPFP during health talk**
Total cost over timeframe	**Don't know**
Additional considerations	
Key stakeholders	**Health care workers, family planning providers, health educators, facility managers, CORPs, HOD health, FP coordinators**
Implementing agency(ies)	**FMoH, SMoH, LGAs, Ips**
Activity 2:	**Provision of IEC materials on PPFP at ANC (e.g. client leaflets, posters)**
Timeframe	**2015-2018**
Evidence of success	**IEC materials on PPFP available at ANC. Number/percentage of health facilities/ANC clinics with IEC materials. Client exit interview**
Total cost over timeframe	**Don't know**
Additional considerations	

Key stakeholders	**Health care workers, family planning providers, health educators, facility managers, CORPs, HOD health, FP coordinators**
Implementing agency(ies)	**FMoH, SMoH, LGAs, Ips**
Activity 3:	**Integrate PPFP with National MNCH, PMCTC and FP policies and strategies, service delivery guideline and quality of care monitoring for ANC services**
Timeframe	**2015-2018**
Evidence of success	**Number of National MNCH, PMCTC, FP policies and strategies that include PPFP. Numbers/Percentage of SDPs that have service delivery quideline for PPFP**
Total cost over timeframe	**Don't know**
Additional considerations	
Key stakeholders	**Health care workers, family planning providers, health educators, facility managers, CORPs, HOD health, FP coordinators**
Implementing agency(ies)	**FMoH, SMoH, LGAs, Ips**
Indicator(s) (Data Source):	Supportive supervision report, baseline and endline report
Future PPFP Program 2:	
Labor and Delivery	
Activity 1:	**Upgrading of maternity service delivery points to provide PPFP including PPIUD, PPI and PPS**
Timeframe	**2015-2018**
Evidence of success	**Proportion of service delivery points that provide PPFP, Number?Proportion of women that received PPFP**
Total cost over timeframe	**Don't know**
Additional considerations	
Key stakeholders	**Health care workers, family planning providers, health educators, facility managers, CORPs, HOD health, FP coordinators**
Implementing agency(ies)	**FMoH, SMoH, LGAs, Ips**
Activity 2:	**Conduct counseling and competency based training for In-service, Pre-service settings including health care workers from Labor and delivery wards and ANC**
Timeframe	**2015-2016**
Evidence of success	**Numbers/percentage of health care workers trained on counseling and competency based training number of providers who achieve 80% of PPFP quality of care standards**
Total cost over timeframe	**Don't know**

Additional considerations	
Key stakeholders	**Health care workers, family planning providers, health educators, facility managers, CORPs, HOD health, FP coordinators**
Implementing agency(ies)	**FMoH, SMoH, LGAs, Ips**
Activity 3:	**Review existing training guideline, protocols, policy document, quality of care standards, checklists and job aids to include PPFP**
Timeframe	**12015-2018**
Evidence of success	**100% of Training guidelines, policy documents, quality of care standards, checklist, jobaids in clude PPFP**
Total cost over timeframe	**Don't know**
Additional considerations	
Key stakeholders	**Health care workers, family planning providers, health educators, facility managers, CORPs, HOD health, FP coordinators**
Implementing agency(ies)	**FMoH, SMoH, LGAs, Ips**
Indicator(s) (Data Source):	Desk review of received materials, supportive supervision report
Future PPFP Program 3:	
POSTNATAL CARE	
Activity 1:	**Initiate PPFP information and counseling in Postpartuce care services**
Timeframe	**2015-2018**
Evidence of success	**Proportion of SDPs offering at least three PPFP methods including LAM, proporting of postpartum women with children under six week of age counseled on PPFP during PNC and PCMTC**
Total cost over timeframe	**Don't know**
Additional considerations	
Key stakeholders	**Health care workers, family planning providers, health educators, facility managers, CORPs, HOD health, FP coordinators**
Implementing agency(ies)	**FMoH, SMoH, LGAs, Ips**
Activity 2:	**Strengthening intra and inter facility referrals**
Timeframe	**2015-2018**
Evidence of success	**Proportion of health facilities with effective referral system**
Total cost over timeframe	**Don't know**
Additional considerations	
Key stakeholders	**Health care workers, family planning providers, health educators, facility managers, CORPs, HOD health, FP coordinators**

Implementing agency(ies)	**FMoH, SMoH, LGAs, Ips**
Activity 3:	**Integrate PPFP with Immunization and Child welfare services**
Timeframe	**2015-2018**
Evidence of success	**Number/proportion of women with a child under 12 month of age who are currently using a contraception mehtod**
Total cost over timeframe	**Don't know**
Additional considerations	
Key stakeholders	**Health care workers, family planning providers, health educators, facility managers, CORPs, HOD health, FP coordinators**
Implementing agency(ies)	**FMoH, SMoH, LGAs, Ips**
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:	**Increased awareness during ANC: Activity one; Include PPFP into the Health Talk during ANC**			
1	Is input about the program being sought from a range of stakeholders?	Yes		There will be series of dicussions to include the PPFP information during health talk at the ANC
2	Are individuals from the implementing agency(ies) involved in the program's design and implementation?	Yes		The FMoH, SMoH, service providers and the community will be involved in the program design and implementation
3	Does the program have mechanisms for building ownership in the implementing agency(ies)?	Yes		More advocacy for buy in by the two states MoH and the community members. The project will be implemented through the two states ministry of health and LGAs
4	Does the program address a persistent health or service delivery problem?	Yes		There high unmet need for family planning in the two states and inadequate trained health care providers, the project will build the capacity of the health care workers to provide quality PPFP service and reduce the high unmet needs.
5	Is the program based on sound evidence and preferable to alternative approaches?	Yes		It is evident that there is high unmet need among high parity women, PPFP implementation will serve as an entry point to general family planning
6	Given its financial and human resource requirements, is the program feasible in the local settings where it is to be implemented?	Yes		Capacity of the existing staff in the local setting will be built to implement the program
7	Is the program consistent with existing national health policies, plans and priorities?	Yes		Based on the National family planning blue print which aimed at reducing unmet need and increasing the National CPR PPFP will largely increase family planning update
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?	Yes		There were series of stakeholders meeting to identify facilities where to start activities and how to scale up in the two states

	Scale-up Consideration	Yes	No	More Information/Action Needed
9	Does the program identify and take into consideration community, cultural and gender factors that might constrain or support its implementation?	Yes		Baseline assessments will be conducted on community consideration for cultural and gender factors which will inform the strategy to be implemented based on commnity and cultural consideration
10	Have the norms, values and operational culture of the implementing agency(ies) been taken into account in the program's design?	Yes		There were all put into consideration during the design of the program in collaboration with all the implementing Agencies
11	Have the opportunities and constraints of the political, policy, health-sector and other institutional factors been considered in designing the program?	Yes		There will be serie as of advocacy for reiwe of policies and training document to include components of key evidence based inteventions
12	Have the activities for implementing the program been kept as simple as possible without jeopardizing outcomes?	Yes		The program will be implemented using simple evidence based best practices
13	Is the program being implemented in the variety of sociocultural and geographic settings where it will be scaled up?	Yes		The program will start in two states and some selected health facilities which will be scaled up in a phased manner
14	Is the program being implemented in the type of service-delivery points and institutional settings in which it will be scaled up?	Yes		It will start with a nmber of selected health facilities and will scale up to other facilities
15	Does the program require human and financial resources that can reasonably be expected to be available during scale-up?	Yes		the program will build the capacity of the existing staff in all the relevant service delivery points and work with them to scale up
16	Will the financing of the program be sustainable?	Yes		The program will do a high powered advocacy to ensure that the program is sustained and will design and implement sustainability exit plan
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?		No	Cacacity building of service provider and their managers for effective service delivery and supportive supervision and monitoring
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?	Yes		Learning agendas for PPFP will be developed for the program, there will be an effective monitoring and evaluation strategy in put in place
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?	Yes		This was initiated during the design of the project
20	Are there plans to advocate for changes in policies, regulations and other health-systems components needed to institutionalize the program?	Yes		The program will advocate for review of family planning training gudelines and materials to include PPFP component
21	Does the program include mechanisms to review progress and incorporate new learning into its implementation process?	Yes		Through program learning activities

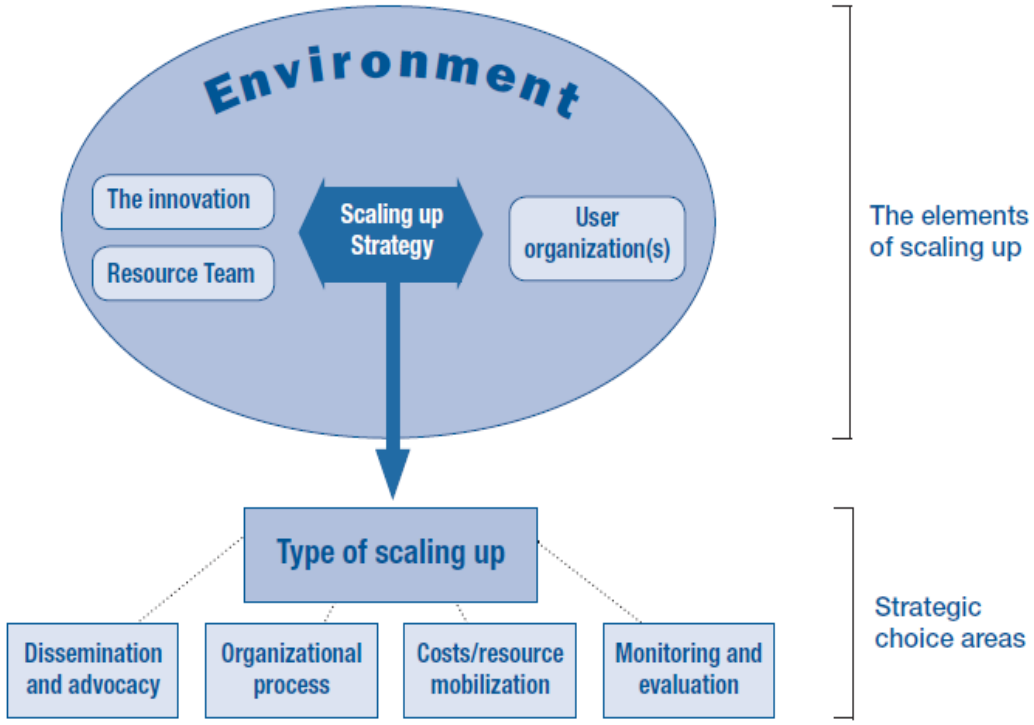
	Scale-up Consideration	Yes	No	More Information/Action Needed
22	Is there a plan to share findings and insights from the program during implementation?	Yes		Program learning agenda has been drawn, Results of assessment, studies, surveys will be shared with donors, federal and state levels and at National and internation conferences, papers will be submitted for publications
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?	Yes		Results of regular assessment will be shared will all stake holders to provide them with evidence and ensure proper understanding of the feasibility and outcome of the program prior to scale up
	Scale-up Consideration	**Yes**	**No**	**More Information/Action Needed**
	Future PPFP Program 2:	**Provision of IEC materias on PPFP at ANC (clients leaflets , posters)**		
1	Is input about the program being sought from a range of stakeholders?	Yes		
2	Are individuals from the implementing agency(ies) involved in the program's design and implementation?	Yes		The country team representiting implementing agencies in the country were involved in the design for implementing the program
3	Does the program have mechanisms for building ownership in the implementing agency(ies)?	Yes		Each implementing agency has a role to play in implementing the program
4	Does the program address a persistent health or service delivery problem?	Yes		IEC materials are key to demand generation and these are lacking in all the health facilities, so ensuring availability of IEC materials will will address some of the inforamtion and demand issues
5	Is the program based on sound evidence and preferable to alternative approaches?	Yes		The baseline assessment conducted reveiled major gaps on availability of IEC materials in the health facilities assessed
6	Given its financial and human resource requirements, is the program feasible in the local settings where it is to be implemented?	Yes		The program will work with the existing structures in the local setting, therefore provides feasibility for implementation
7	Is the program consistent with existing national health policies, plans and priorities?	Yes		The program will conduct advocacy for review of existing national 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?	Yes		The team reached agreement on where and to what extent activities will be scaled-up
9	Does the program identify and take into consideration community, cultural and gender factors that might constrain or support its implementation?	Yes		The community, cultural and genders factors have all been put into consideration in the design of the program
10	Have the norms, values and operational cultrue of the implementing agency(ies) been taken into account in the program's design?	Yes		
11	Have the opportunities and constraints of the political, policy, health-sector and other institutional factors been considered in designing the program?	Yes		The program is designed in a way that it carries along all stake holders so as to maximize opportunities and address any political, policy, health-sector and other institutional factors
12	Have the activities for implementing the program been kept as simple as possible without jeopardizing outcomes?	Yes		The program will be implemented using a simple approach and existing staff

	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?	Yes		The program will be implemented in a phased manner in a veriety of socio-cultural and geografical setting that cut across the states
14	Is the program being implemented in the type of service-delivery points and institutional settings in which it will be scaled up?	Yes		The program planned to be implemented in six pilot service delivery points in six health facilities in order to use evidence for scale up to other health facilities
15	Does the program require human and financial resources that can reasonably be expected to be available during scale-up?	Yes		though theprogram will work with existing human resources, it requires finacila resources to be available during scale up
16	Will the financing of the program be sustainable?	Yes		Buy in by the states would have been achieved and MOUs will be agreed upon with the states as part of sustainability plans
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?		No	There are plans to train health care workers involved in ANC and delivery on effective counseling using the Balanced Counseling Strategy. This will empower them to effectively use the IEC materials
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?	Yes		Ther will be both fomative and sumative assessment with some regular follow up assesments inbetween. All will be appropriately documented
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?	Yes		This was initiated during the development of the country work plan
20	Are there plans to advocate for changes in policies, regulations and other health-systems components needed to institutionalize the program?	Yes		The program will be advocation for review of family planning policy, guidelines, posters, job aids to include PPFP content for institutionalization
21	Does the program include mechanisms to review progress and incorporate new learning into its implementation process?	Yes		Results of the regular assessment will be used to review progress and incoporate new learning into its implementation process
22	Is there a plan to share findings and insights from the program during implementation?	Yes		Finding will be shared at Federal and state levels as well as at both national and intenation forah
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?	Yes		All the assessments results will be shared among key stake holders to show evidence related to feasibility and outcome of the propram before scale up
	Scale-up Consideration	**Yes**	**No**	**More information/action needed**
Future PPFP Program 3:		**Care monitoring for ANC services**		
1	Is input about the program being sought from a range of stakeholders?	Yes		The team agreed on the need to to provide regular supportive supervision to monitore the quality of care at ANC level
2	Are individuals from the implementing agency(ies) involved in the program's design and implementation?	Yes		Implementing agencies represented at the meeting all participated in the design of the program
3	Does the program have mechanisms for building ownership in the implementing agency(ies)?	Yes		Evry body has a responsibilities and every implementing partner will own up to his responsibilities

	Scale-up Consideration	Yes	No	More Information/Action Needed
4	Does the program address a persistent health or service delivery problem?	Yes		The progrma will provide monitoring and support providers through on-the-job training and mentoring to ensure services are provided in a qualitative manner, this will adress the issue of knowledge and skills
5	Is the program based on sound evidence and preferable to alternative approaches?	Yes		
6	Given its financial and human resource requirements, is the program feasible in the local settings where it is to be implemented?	Yes		The program is feasible in the local setting as there are already service providers providing ANC and delivery services and we plan to work with the existing structures but require finacial support for capacity building and strenthening of the service delivery point to provide quality PPFP counseling and services
7	Is the program consistent with existing national health policies, plans and priorities?	Yes		There is a national priority for reducing unmet need for family planning and increasing the national CPR to achieve the Country's commitment to the FP 2020 of increasing the national CPR from 11% to 36% by the year 2018. PPFP program will increase contraceptives use, reduce unmet needs and increase the national CPR
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?	Yes		At the design of the program, the team agreed to implement the program in selected pilot health facilities to generate evidence for scale up
9	Does the program identify and take into consideration community, cultural and gender factors that might constrain or support its implementation?	Yes		The community, cultural and gender factors have all been put into consideration by the project
10	Have the norms, values and operational cultrue of the implementing agency(ies) been taken into account in the program's design?	Yes		All have been taken into consideration
11	Have the opportunities and constraints of the political, policy, health-sector and other institutional factors been considered in designing the program?	Yes		We considered all the opportunities for working closely with the facility managers to provide institutional monitoring and supervision
12	Have the activities for implementing the program been kept as simple as possible without jeopardizing outcomes?	Yes		The activity will be implemented at the existibg facilities by the same facility staff
13	Is the program being implemented in the variety of sociocultural and geographic settings where it will be scaled up?	Yes		The program will be implemented starting with the pilot state, LGAs and health facilities and will gradually be scaled - up at national levele
14	Is the program being implemented in the type of service-delivery points and institutional settings in which it will be scaled up?	Yes		Implementation will be carried out in service delivery points and institutions that provide opportunity for scale-up
15	Does the program require human and financial resources that can reasonably be expected to be available during scale-up?	Yes		Human and finacial reasources are required for scale up of the program

	Scale-up Consideration	Yes	No	More Information/Action Needed
16	Will the financing of the program be sustainable?	Yes		As the program move to scale the federal and state government should be able to sustain the program with some support from implementing partmners
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?		No	There is need for health system strengthening to ensure they have the capacity to implement the program
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?	Yes		Using the baseline inbetween program and endline assessments
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?	Yes		The program has started and will continue to engage donors and technical partners to build based for finacial 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?	Yes		Serries of advocacy will be conducted to ensure policy regulations to include PPFP contents
21	Does the program include mechanisms to review progress and incorporate new learning into its implementation process?	Yes		This has been planned during the project design
22	Is there a plan to share findings and insights from the program during implementation?	Yes		This will be carried out at meetings and conferences
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?	Yes		All key stke holders have an understanding about the importance of having adequate evidence related to the feasibility and outcome of the project priority for scale-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:	Nigeria	Country Coordinator:	Dr Kayode Afolabi

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	Submission of trip report and debreifing of the FP focal person and the Minister of Health an d the CTC, AAFP on the FP 2020 global meeting disemination of the MEC 2015 WHO recomendation	Nigeria Team	Head of Family health Department	30/06/2015	Delay in appointment of new Minister of Health. Nigeria has a new Government
2	Presentation of meeting report at the CTC and AAFP meeting	Nigerian Team	Head of Family health Department	25/06/2015	None
3	Review and updating of existing FP document with PPFP content in line with new MEC recommendation e.g. Guidelines, Protocols, training materials, Jobaids , IEC materials, posters	WHO, Jhpiego, MSION, NURHI	Head of Family health Department	October 23rd	Funding given that the organizations did not budget for this activityy for this year. WHO is funding
4	PPFP activities included in workplans and budgets of FP programs	FMoH	The Palladium Group, UNFPA, MCSP, MSION	31st October 2015	PPFP funding not included in FMoH 2015 budget. Government and partners to include PPFP in workplan and budget for 2016
5	Training of Master trainers on PPFP at the national level	FMoH	Jhpiego/MCSP, MSION, UNFPA, MNCH 2, WHO	Dec-15	Funding may limit no of persons and cycles of training. Identifying the right persons with the right competencies to train. AAFP will work with FMoH to draw up criteria for selecting master trainers
6	Training of State trainers on PPFP	SMoH	FMoH & partners	Feb-16	Only States with donor-supported programs are likely to implement the policy. Advocacy will be needed for states without partner support

	Task	Primary person responsible	Secondary person responsible	Deadline	What problems do you anticipate? What will you do when you encounter these (or other) problems?
7	Selection of pilot PPFP project sites	FMoH	FP partners supported sites e.g. MSION, Jhpiego/MCSP, NURHI	Novemeber 30 2015	Partners may not all do the selection at the same time
8	Strengthening of selected sites for PPFP counseling and clinical services	FP partners supported sites e.g. MSION, Jhpiego/MCSP, NURHI	SMoH	Jan-16	Resources constraint.
9	Training of health care workers to provide PPFP services including PPIUD and PPI counseling and insertions & removals	FP partners supported sites e.g. MSION, Jhpiego/MCSP, NURHI	SMoH, SPHCA	Mar-16	Staff atrition; this could be addressed by signing MOUs with HMB and facility managers to ensure that trained staff remain in the unit and facilities for at least two years and ensure they step down the training to others in the unit. Advocacy to ensure industrial harmony. Train more service providers.
10	Engage DPRS in review of HMIS	FMoH	Jhpiego/MSCP, MSION, WHO, AAFP	October 2015 - on-going	Dependent on the government agency's timelines for the review of NHMIS forms.
11	Demand generation and community engagement	FP partners SFH, MSION, NURHI, NPHCDA, UNFPA	SMOH,SPHCDA, MAMA, Mamaye LGAs	October 2015 - on-going	Funding given that the organizations did not budget for this activityy for this year
12	Printing and dissemination of IEC materials, Posters, Client leaflets, MEC quidelines and Job aids	FMoH Jhpiego/MCSP, MISON, SFH, WHO	SMoH, LGAs	10/1/2015 - on-going	Resources constraint.
13					
14	Initiate PPFP information and Counseling in Postpartum care services	Jhpiego/MCSP, MISON, SFH,	SMoH, SOHCDA, LGAs,	November 2015 on-going	None

	Task	Primary person responsible	Secondary person responsible	Deadline	What problems do you anticipate? What will you do when you encounter these (or other) problems?
15	Strengthening intra and inter facility referrals	Jhpiego/MCSP, MISON, SFH, NURHI	SMoH, LGAs, FMoH	November 2015 on-going	Transportation & communication especially from household to health facilities. This could be addressed by engaging the community and supporting them to have emergency transport system
16	Integrate PPFP with Immunization, New-born care and Child welfare services	SMoH, SPHCDA, Jhpiego, MISON, SFH, NURHI	SMoH, LGAs, SPHCDA	December 2015 on-going	If services are not available on site, women may not go for referrals due to distance; work with facility management to ensure PPFP services are available
17	Ensuring availability of FP Commodities at service delivery points	FMoH/NPHCDA, UNFPA, USAID |DELIVER	SMoH, LGAs, SPHCDAs	On-going with existing FP programs	Commodity stock out due to logistics management and transportation issues; Engage LGA and community to support some logistics issues, Encourage emergency request system, strengthen CLMS
18	Review of coverage and measurement of quality PPFP service indicators	FMoH, Jhpiego/MCSP, MISON, WHO, IPs, NURHI	SMoH, LGAs, F, NGOs	On -going	As above
19					
20					