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.

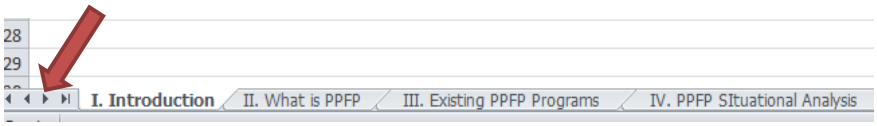
(4) For each of the future PPFP programs, complete a detailed PPFP Implementation Plan and consider how each program can best be scaled up to reach national and global family planning goals.

(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:



USAID FROM THE AMERICAN PEOPLE

Maternal and Child Survival Program

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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]

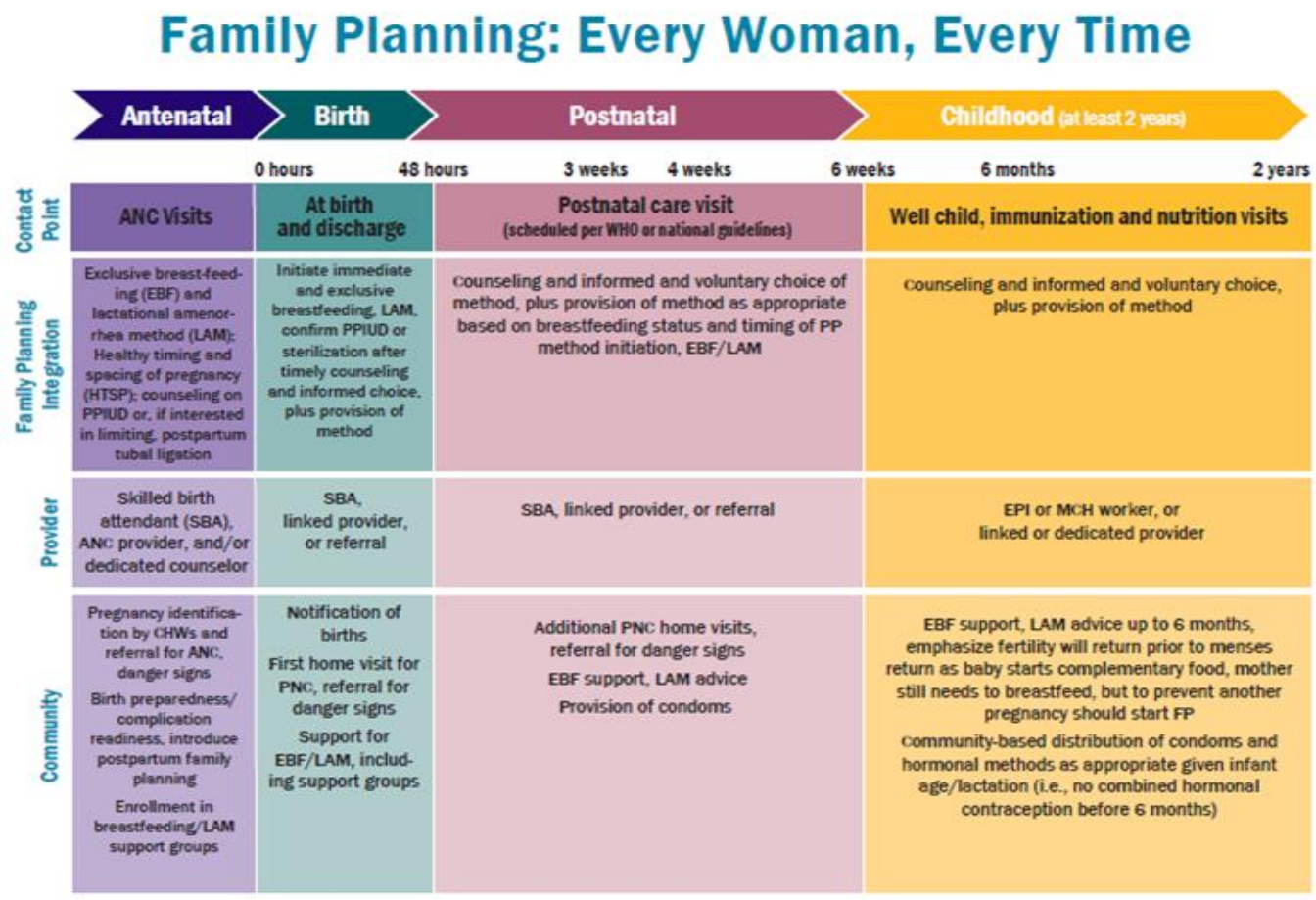
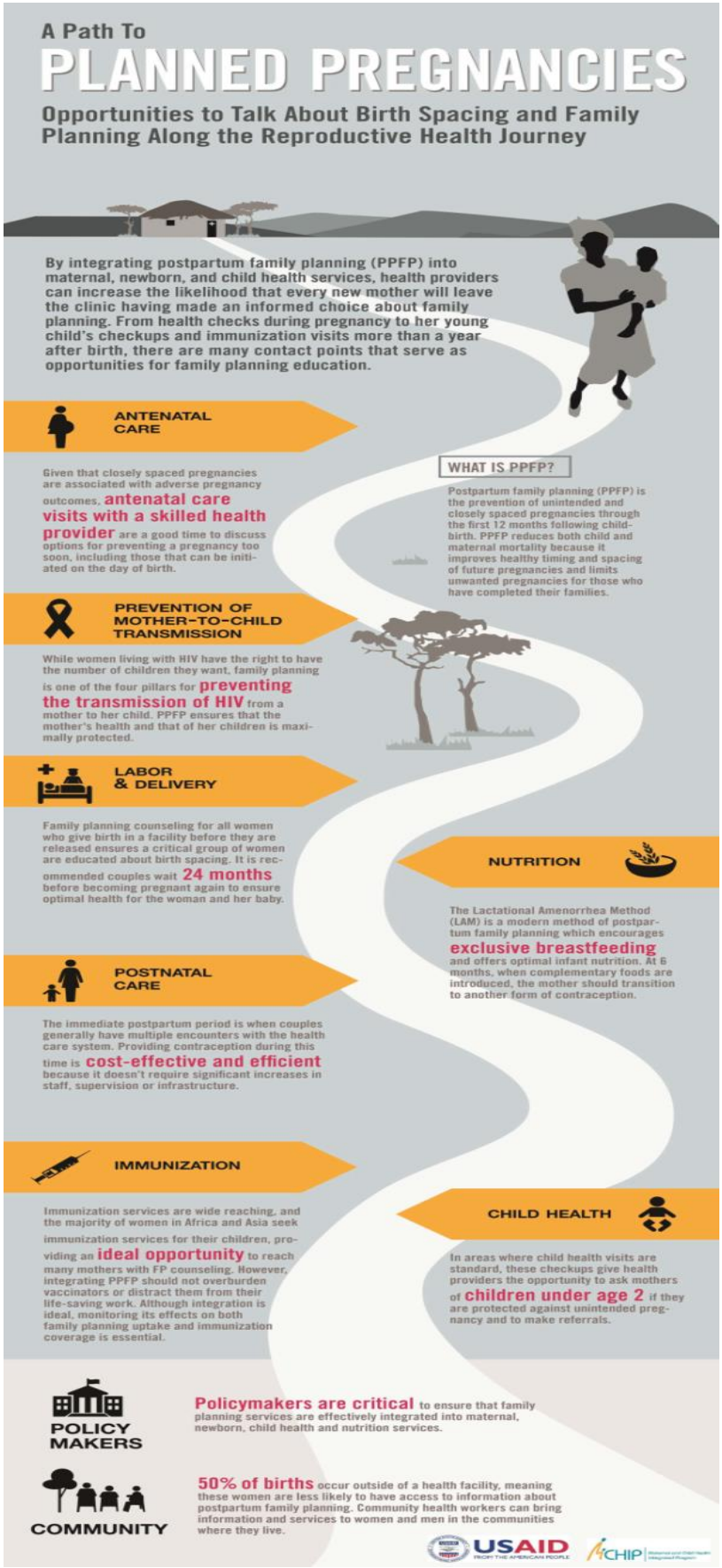


Figure 2. PPFP Integration Opportunities [MCHIP 2013]



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Country:	Rwanda	Country Coordinator:	Dr Fidele Ngabo

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:	**PPIUD**
Activity 1:	**PPIUD feasability and acceptability study**
Timeframe	**2010 to 2013**
Evidence of success	**study completed and whown PPIUCD is acceptable for mothers and providers, feasible at hospital and HC level, PPIUD insertion can be done by physicians and Nurses/midwives. MOH and stakeholders recommende for its scale up**
Total cost over timeframe	
Has this activity been scaled? Why or why not?	**partially**
Key stakeholders	**MOH/ UNFPA/USAID/WHO and its Implementing partners that included Jhpiego and FHI 360, FP TWG members**
Implementing agency(ies)	**JHPIEGO, FHI360**
Activity 2:	**Scale up of PPFP/PPIUD in selected districts by UNFPA**
Timeframe	**2014 - 2018**
Evidence of success	**NA FOR THE MOMENT**
Total cost over timeframe	**20,000$**
Has this activity been scaled? Why or why not?	
Key stakeholders	**USAID,UNFPA,WHO, DH, HC**
Implementing agency(ies)	**UNFPA,MOH,DH,HC**
Activity 3:	**Integration of PPFP in other maternal health services (ANC)**
Timeframe	**2007**
Evidence of success	**ANC card**
Total cost over timeframe	

Has this activity been scaled? Why or why not?	yes
Key stakeholders	MOH, DH,HC
Implementing agency(ies)	WHO,UNFPA,USAID
Indicator(s) (Data Source):	
Existing PPFP Program 2:	Integration of PPFP in immunization
Activity 1:	sensitization during the immunization session
Timeframe	
Evidence of success	2010
Total cost over timeframe	
Has this activity been scaled? Why or why not?	yes
Key stakeholders	MOH, DH,HC
Implementing agency(ies)	WHO,UNFPA,USAID
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:	Integration of PPFP in community level
Activity 1:	capacity building of CHWs
Timeframe	2012
Evidence of success	availability and used of counseilling card in the community
Total cost over timeframe	
Has this activity been scaled? Why or why not?	yes
Key stakeholders	MOH, DH,HC
Implementing agency(ies)	WHO,UNFPA,USAID
Activity 2:	provision of commodities
Timeframe	2012
Evidence of success	Register, SISCOM
Total cost over timeframe	
Has this activity been scaled? Why or why not?	YES
Key stakeholders	MOH
Implementing agency(ies)	WHO,UNFPA,USAID
Activity 3:	
Timeframe	
Evidence of success	
Total cost over timeframe	
Has this activity been scaled? Why or why not?	
Key stakeholders	
Implementing agency(ies)	
Indicator(s) (Data Source):	

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IV. PPFP Situational Analysis

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

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
DEMOGRAPHIC DATA				
1	Total population (as of mid-2014)	Population Reference Bureau (see Tab IX)	10,996,891	Population that will benefit from families reaching desired size
2	Annual population growth, %	Population Reference Bureau "Rate of Natural Increase" (see Tab IX)	2,6	Pace of population change that could be slowed with PPFP
3	Crude birth rate	Population Reference Bureau (see Tab IX)	31 births per 1,000 inhabitants.	Numbers of births occurring
4	Number of women of reproductive age (WRA)	Population Reference Bureau (see Tab IX)	2760219.641	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)	343,480	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)	4,0	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)	3	Compare with #6 on total fertility rate
8	Adolescent fertility rate	Population Reference Bureau (see Tab IX)	6,1%	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)		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)		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)		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)		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)	45	Population of women who are currently using family planning
15	Your country's CPR target	Government website or other publicly available reference	70	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)	33,4% 6,8% 0,5% 0,8$	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)	98	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)		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)	69	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)		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	18%	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		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)		Population that can be reached with PPFP methods at routine immunization visits or through referrals from these visits
24	OPTIONAL: Percentage of women who experience violence during pregnancy, childbirth or for using family planning	Possibly Demographic and Health Survey; if not, use other available data or estimations		Importance of sensitizing health workers to this population, including possible reproductive coercion and preparing them to sensitively discuss gender-based violence mitigation or prevention strategies integrated with PNC/PPFP services. Also role of discreet/clandestine methods for these women.
25	Percentage of unsafe abortions	WHO, Unsafe Abortion, 2008 http://whqlibdoc.who.int/publications/2011/9789241501118_eng.pdf?ua=1 [regional estimates only]		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	www.presidency.gov.rw/component/content/article/president-kagame-gives-keynote-speech-at-london-family-planning-summit	Country-level, public financial commitment to invest in FP
27	Statement for Collective Action for PPFP Country Endorsement	http://www.mchip.net/actionppfp/		Country-level, public support/champions for PPFP
28	National FP Strategy	Government website or other publicly available citation		Where PPFP should be included or enhanced to affect national policy
29	FP Costed Implementation Plan	Government website or other publicly available citation		Where PPFP programs with budgets should be included or enhanced to affect national policy

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
30	Provide PPFP Implication for: "Provider cadres that are authorized to deliver PPFP services"	http://www.optimizemnh.org/intervention.php		

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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:	**PPIUD**			
Health System Dimension	**Strenths**	**Weaknesses**	**Opportunities**	**Threats**
	Health Services			
1	a. Public sector	High commitment of leaders at all levels	Delay of scale up	Acceptance of FP methods	
	b. Faith-based/non-governmental organization (NGO)	Involvement of NGOs		Commitment of partners	
		Good collaboration between the MOH and parterners			
	c. Private sector			Avaialability of FP	Limitation due to non subsidized FP services
2	Health management information system (HMIS)		HMIS doesn't cover all FP2020 indicators and disaggregation by age is missing	Existing of FP indicators in the HMIS system	
3	Health workforce	acceptable by providers			
4	Medicines and technology	existance of procurement system			some rumours on IUD users.
5	Health financing				Insuficient financial resources
6	Leadership and governance	Decision for scaling up has been made			

	Health System Dimension	Strenths	Weaknesses	Opportunities	Threats
7	Community and sociocultural				
	a. Community-based	Awereness of FP		opportunities related to integration(immunization, nitrution, MNCH)	
	b. Mobile outreach			MCH weesk twice a year	
	c. Social marketing				

Existing PPFP Program 2:

	Health System Dimension	Strenths	Weaknesses	Opportunities	Threats
1	Health Services				
	a. Public sector				
	b. Faith-based/NGO				
	c. Private sector				
2	HMIS				
3	Health workforce				
4	Medicines and technology				
5	Health financing				

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
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
1	Health Services				
	a. Public sector				
	b. Faith-based/NGO				
	c. Private sector				
2	HMIS				
3	Health workforce				
4	Medicines and technology				
5	Health financing				
6	Leadership and governance				

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

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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:	**Post training follow up for 5 districts (UNFPA)**
Timeframe	**July to September**
Evidence of success	**Number of women receiving PPFP**
Total cost over timeframe	**20,000$**
Additional considerations	
Key stakeholders	**DH, HC**
Implementing agency(ies)	**UNFPA**
Activity 2:	**training of providers from 10 districts**
Timeframe	**October 2015 to June 2016**
Evidence of success	
Total cost over timeframe	**140,000$**
Additional considerations	
Key stakeholders	**DH, HC**

Implementing agency(ies)	OB, MCSP,
Activity 3:	Supervision/mentorship in trained districts (10)
Timeframe	January to September 2016
Evidence of success	
Total cost over timeframe	42,000$
Additional considerations	
Key stakeholders	MOH/MCSP/DH/HC
Implementing agency(ies)	MCSP, MOH
Indicator(s) (Data Source):	number of HP mentored, number of PPFP new users Number of trained HP
Future PPFP Program 2:	
Activity 1:	Awareness meeting with local authorities from 30 distrits (PPFP)
Timeframe	July to september 2015
Evidence of success	Mobilisation sessions organized
Total cost over timeframe	7,000$
Additional considerations	during this meeting for FP in general but focussing on the early initiation of FP use.
Key stakeholders	Districts Hospitals, districts administration, civil society,
Implementing agency(ies)	MCSP, MoH/MCCH
Activity 2:	procurement of PPIUD kits to health facilities
Timeframe	January to December 2016
Evidence of success	Kit available in HF
Total cost over timeframe	20,000$
Additional considerations	
Key stakeholders	DH,HC
Implementing agency(ies)	UNFPA, MCSP
Activity 3:	
Timeframe	
Evidence of success	
Total cost over timeframe	
Additional considerations	
Key stakeholders	

Implementing agency(ies)	
Indicator(s) (Data Source):	
Future PPFP Program 3:	
Activity 1:	
Timeframe	
Evidence of success	
Total cost over timeframe	
Additional considerations	
Key stakeholders	
Implementing agency(ies)	
Activity 2:	
Timeframe	
Evidence of success	
Total cost over timeframe	
Additional considerations	
Key stakeholders	
Implementing agency(ies)	
Activity 3:	
Timeframe	
Evidence of success	
Total cost over timeframe	
Additional considerations	
Key stakeholders	
Implementing agency(ies)	
Indicator(s) (Data Source):	

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VII. Considerations for Scale-up

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

	Scale-up Consideration	Yes	No	More Information/Action Needed
Future PPFP Program 1:				
1	Is input about the program being sought from a range of stakeholders?	yes		FP TWG members :USAID, UNFPA, MOH, NGOs (Jhpiego/MCSP/ FHI, Georgetown university, JSI, ARBEF, …..)
2	Are individuals from the implementing agency(ies) involved in the program's design and implementation?	yes		Members TWGs
3	Does the program have mechanisms for building ownership in the implementing agency(ies)?	yes		
4	Does the program address a persistent health or service delivery problem?	yes		
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		
7	Is the program consistent with existing national health policies, plans and priorities?	yes		
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		
9	Does the program identify and take into consideration community, cultural and gender factors that might constrain or support its implementation?	Yes		
10	Have the norms, values and operational culture 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		
12	Have the activities for implementing the program been kept as simple as possible without jeopardizing outcomes?	Yes		

	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		
14	Is the program being implemented in the type of service-delivery points and institutional settings in which it will be scaled up?	yes		
15	Does the program require human and financial resources that can reasonably be expected to be available during scale-up?	Yes		
16	Will the financing of the program be sustainable?	Yes		
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?	Yes		
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?	Yes		
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		
20	Are there plans to advocate for changes in policies, regulations and other health-systems components needed to institutionalize the program?	Yes		
21	Does the program include mechanisms to review progress and incorporate new learning into its implementation process?	Yes		
22	Is there a plan to share findings and insights from the program during implementation?	Yes		
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		

	Scale-up Consideration	Yes	No	More Information/Action Needed
Future PPFP Program 2:				
1	Is input about the program being sought from a range of stakeholders?			
2	Are individuals from the implementing agency(ies) involved in the program's design and implementation?			
3	Does the program have mechanisms for building ownership in the implementing agency(ies)?			
4	Does the program address a persistent health or service delivery problem?			

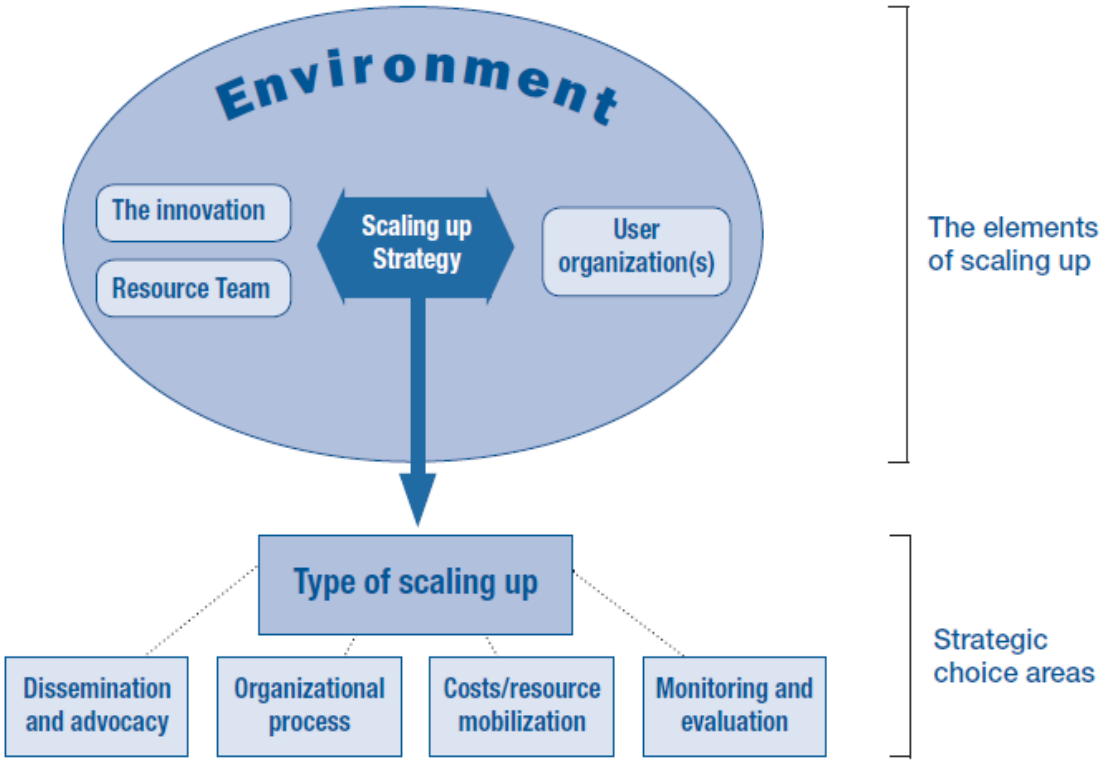
	Scale-up Consideration	Yes	No	More Information/Action Needed
5	Is the program based on sound evidence and preferable to alternative approaches?			
6	Given its financial and human resource requirements, is the program feasible in the local settings where it is to be implemented?			
7	Is the program consistent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

	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?			
16	Will the financing of the program be sustainable?			
17	Does the health system currently have the capacity to implement the program? If not, are there plans to test ways to increase health-systems capacity?			
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?			
19	Is there provision for early and continuous engagement with donors and technical partners to build a broad base of financial support for scale-up?			
20	Are there plans to advocate for changes in policies, regulations and other health-systems components needed to institutionalize the program?			
21	Does the program include mechanisms to review progress and incorporate new learning into its implementation process?			

	Scale-up Consideration	Yes	No	More Information/Action Needed
22	Is there a plan to share findings and insights from the program during implementation?			
23	Is there a shared understanding among key stakeholders about the importance of having adequate evidence related to the feasibility and outcomes of the program prior to scaling up?			

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



USAID FROM THE AMERICAN PEOPLE

Maternal and Child Survival Program

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

PPFP Country Programming Strategies Worksheet

Country:	Rwanda	Country Coordinator:	Dr Fidel NGABO

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	Production of tools (Guidilines, protocol, counseling tools),	MOH	Partners	September	
2	Training of health providers on PPIUD	MOH	Partners	Sep-16	
3	Post Training follow up	MOH	Partners	December	
4	Conducting mentoship	MOH	Partners	continuous	
5	Integration of FP in ANC card	MOH	Partners	September	
6	Establish the PPFP indicator in HMIS	MOH	Partners	July	
7	Development of PPFP M&E framework	MOH	Partners	September	
8	Integration of PPPF strategic plan into the existing FP strategic plan	MOH	Partners	December	
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					