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.

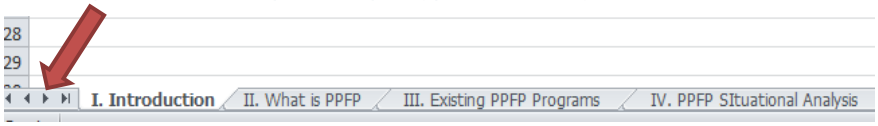
(4) For each of the future PPFP programs, complete a detailed PPFP Implementation Plan and consider how each program can best be scaled up to reach national and global family planning goals.

(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]

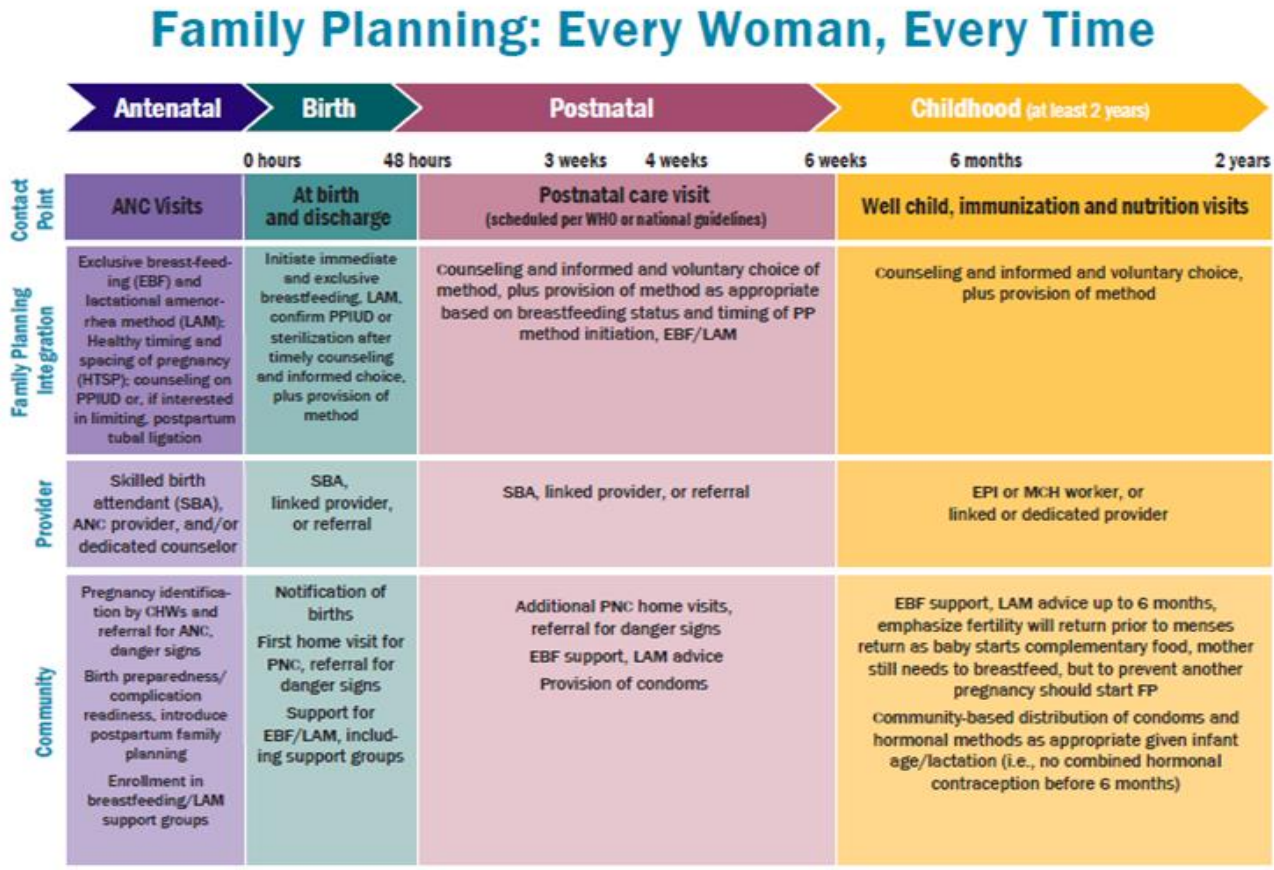
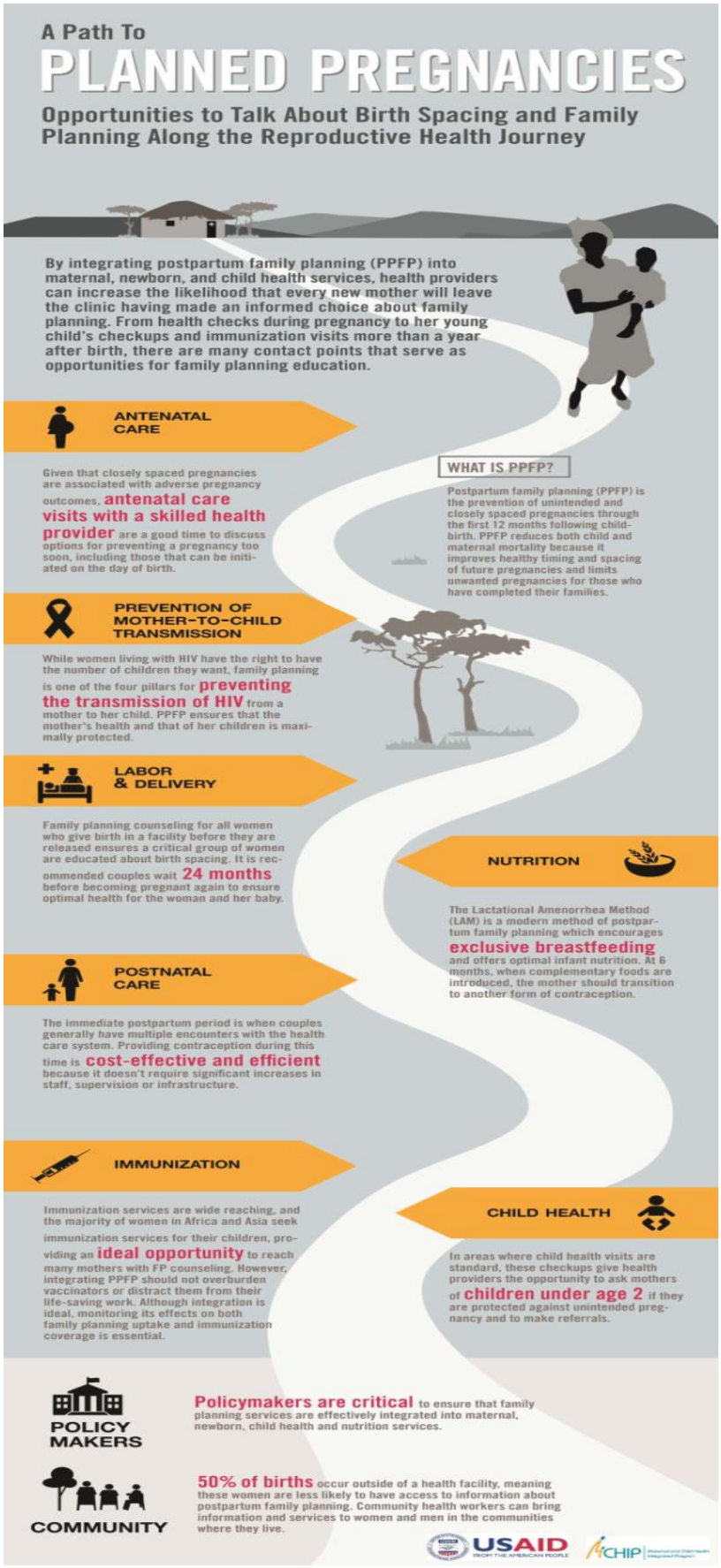


Figure 2. PPFP Integration Opportunities [MCHIP 2013]



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Country:	Afghainstan	Country Coordinator:	Dr. Rasheda Furmoli

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:	**Initiative Postpartum Family Planning**
Activity 1:	**Expanding service delivery system at Health Facility and Health Post level**
Timeframe	**November 2009 - Jan 2014**
Evidence of success	**664 Health Facilities were oriented on PPIUCD, (this was only orientation to HF staff on PPIUCD, Not a PPIUCD training). Further, 6465 CHWs were at Health Posts level oreinted on LAM. During the event LAM brochures were distirubuted to CHWs, this information was also provided to number of Provincial Public Health Management team and Members of Community Health Councils.**
Total cost over timeframe	**NA**
Has this activity been scaled? Why or why not?	**The project was initiated by USAID funded Helath Service Support Project in 13 provinces during 2009. The pupose was to orient Health Facility staff, Community Health Worksers, Health Councils and Provincial Public Health Management team on PPFP. during 2012 the HSSP was officialy closed and activities were handed over to BPHS contractors (Basic Package of Health Services) only in 13 provinces. This means the activity was not nationalized and subsequently it was not properly followed up after 2014. There is plan to revitalize the activities through new FP/MNCH project that is funded by the USAID.**
Key stakeholders	**MoPH, USIAD, HSSP/Jhpiego**
Implementing agency(ies)	**NGOs (BPHS Implementing Partners)**
Activity 2:	**Training of health care providers on PPIUCD in 4 regions (4 maternity hospitals in Kabul and 3 regional hospitals of Herat, Balkh and Nangarhar).**
Timeframe	**From 2010 to date**
Evidence of success	**Training reports**
Total cost over timeframe	**NA**
Has this activity been scaled? Why or why not?	**The activity was initiatied by Jhpiego in Kabul maternity hospitals and then scaled up to regions (at 3 regional hospitals)**
Key stakeholders	**MoPH, Jhpiego and UNFPA**

Implementing agency(ies)	**MoPH**
Activity 3:	
Timeframe	
Evidence of success	
Total cost over timeframe	
Has this activity been scaled? Why or why not?	
Key stakeholders	
Implementing agency(ies)	
Indicator(s) (Data Source):	
Existing PPFP Program 2:	
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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Country:	Afghanistan	Country Coordinator:	Dr. Rasheda Furmoli

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)	30 million based on CSO report 2014.	Population that will benefit from families reaching desired size
2	Annual population growth, %	Population Reference Bureau "Rate of Natural Increase" (see Tab IX)	2.03 based on CSO report 2014.	Pace of population change that could be slowed with PPFP
3	Crude birth rate	Population Reference Bureau (see Tab IX)	35.6 based on AMS 2010.	Numbers of births occurring
4	Number of women of reproductive age (WRA)	Population Reference Bureau (see Tab IX)	6.5 million, based on UN population devision.	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)	12,00,000 the estimation is based on 4% of total population.	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)	5.1 based on AMS 2010.	Number of births per woman with opportunity for PPFP—compare with #7 on ideal family size

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
7	Ideal family size	Demographic and Health Survey (see Tab IX)	7	Compare with #6 on total fertility rate
8	Adolescent fertility rate	Population Reference Bureau (see Tab IX)		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)		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

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
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)	13.8% Based on NRVA 2012.	Population of women who are currently using family planning
15	Your country's CPR target	Government website or other publicly available reference	40% by end of 2016, based on RH strategy.	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)	No breakdown available.	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)	54% based on AHS 2013	Population that can be reached with PPFP messages early in the MNCH continuum of care and receive service after delivery with systematic implementation

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
18	Percentage of women practicing exclusive breastfeeding (EBF) at: ➢ 2 months ➢ 5–6 months	Demographic and Health Survey (see Tab IX)	54.9% based on AHS 2012. No breakdown availble on age group	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)	30% based on AHS 2013 at public facility level.	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)	National estimated as 70%	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	28% based on AMS 2010.	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		Population that can be reached with certain PPFP methods that are available in the immediate postpartum period (i.e., prior to discharge) or that need to be introduced at later contact points

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
23	Immunization rates for: ➢ Birth BCG ➢ DPT1 ➢ DPT3 ➢ Drop-out rate between DPT1 & DPT3	Demographic and Health Survey (see Tab IX)	Children having received all vaccines (12-23 months) is 29.9 %. We couldn't find the breakdown of the vaccines	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	Yes, the FP is a major component of the RH strategy.	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	The FP is the major component of the RH strategy.	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	The RH strategy is costed with the FP component.	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	Estimated number of providers trained by RHD for Implant are around 70 and for PPIUCD are 250.	

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Country:	Afghanistan	Country Coordinator:	Dr. Rasheda Furmoli

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:	**November 2009 - Jan 2014**

	Health System Dimension	Strenths	Weaknesses	Opportunities	Threats
1	Health Services				
	a. Public sector	Project already implemented in 13 provinces	Remaining 21 provinces were out of coverage	Learning Resources Packages as well as , reporting template and guidines are availibale	Insecurity, staff turover, low community awareness, limited resources including funding
	b. Faith-based/non-governmental organization (NGO)	the project already implemented in 13 provinces	the remaining 21 provinces were out of coverage	Learning Resources Packages as well as , reporting template and guidines are availibale	Insecurity, staff turover, low community awareness, limited resources including funding
		Implementing partners commitment	Poor monitoring and supervision system at different level	Checklists and other tools are availible for further use	Insecurity, staff turover, low community awareness, limited resources including funding
	c. Private sector	Availibility of more private Health Facilities	Poor reporting and responsive system with lack of coordination with the public sector.	Learning Resources Packages as well as , reporting template and guidines are availibale	Staff turover, supply of commodity and resources including funding
		Intreasted for scaling of PPFP in private sector clinic	PPFP is not implemented in by Private sector	Learning Resources Packages as well as , reporting template and guidines are availibale	Staff turover, supply of commodity and resources including funding
2	Health management information system (HMIS)	HMIS reporting system is in place at national level and covered all key indicators including FP	poor systematic data review, verification and analysis at different level including Health Facility, Provincial and central	HMIS replica (data analysis), data use guideline as well as , reporting template and checklists are available at provincial and central level	staff turover and long term commitment in terms of regula and systematic data analysis and response
3	Health workforce	Manpower, full group of employees force of workers available	Poor stewardship role of Ministry of Public Health	Donor comittment, availibility of development projects etc	Classical and traditional governmental process both at central and provincial level

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
4	Medicines and technology	Availibility of medicinces and technology	The processes are donor driven and contracted out to NGOs, which is not a sustainable system.	Donor comittment and availibility of fund for the medicinces	Classical and traditional governomental process both at central and provincial level
5	Health financing	Fund availibility	Healthcare services contracted out with NGOs, the sustainability of the programe is alaways a question.	Donors are still comitted to fund the system.	Insecurity, staff turover, low community awareness, resources including funding
6	Leadership and governance	Ministry of Public Health commitment	Poor monitoring and supervision system at different level	Checklists and other M&E tools are availible for further use	Insecurity, staff turover, low community awareness, resources including funding
7	Community and sociocultural				
	a. Community-based	Community Health Counsel	poor community mobilization and active participation	Availibility of Community Health Counsel	Geographical barriers, Insecurity, staff turover, low community awareness, resources including funding
		Community Health Workers	Poor skills and knowledge of Community Health Worksers	Availibility of Community Health Workers	Geographical barriers, Insecurity, staff turover, low community awareness, resources including funding
		Commodities at Health Posts level	Low utilization of FP methos at community level	Availibility of Commodities at Health Posts level	Geographical barriers, Insecurity, staff turover, low community awareness, resources including funding
	b. Mobile outreach	Mobile Health Services in remote areas	limitation of services and irregular schedules	Availibility of Mobile Health Services in remote areas	Geographical barriers, Insecurity, staff turover, low community awareness, resources including funding
		Commodities at mobile health failities	Low utilization of FP methods at mobile health facilities	Availibility of Commodities at mobile health failities	Geographical barriers, Insecurity, staff turover, low community awareness, resources including funding
	c. Social marketing	NGOs facilitaed social marketing at national level	Low utilization of FP methos at private facilities	Availibility of comodities in social market	Geographical barriers, Insecurity, staff turover, low community awareness, resources including funding

Existing PPFP Program 2:					
Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
1	Health Services				
	a. Public sector				

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
1	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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PPFP Country Programming Strategies Worksheet

Country:	Afghanistan	Country Coordinator:	Dr. Rasheda Formuli

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:	
National FP guideline on recent WHO, MEC updated and implemented.	
Activity 1:	**Establish technical working group to update the FP guideline.**
Timeframe	**2015**
Evidence of success	**Updated national FP guideline**
Total cost over timeframe	**5000 USD**
Additional considerations	**Political Commitment and Donor Support**
Key stakeholders	**MoPH, WHO, UNFPA, MSI and Jhpiego and local NGOs**
Implementing agency(ies)	**MoPH and RH stakeholders**
Activity 2:	**Revise and print FP LRPs to include PPFP methods**
Timeframe	**2015**
Evidence of success	**Revised PPFP LRP**
Total cost over timeframe	**30,000**
Additional considerations	**Political Commitment and Donor Support**
Key stakeholders	**MoPH and RH stakeholders**

Implementing agency(ies)	MoPH, UN agencies and BPHS/EPHS implementing NGOs
Activity 3:	Train master trainers and service providers on revised LRPs
Timeframe	2015 - 2017
Evidence of success	Training reports and post training follow up reports
Total cost over timeframe	Will be determined later
Additional considerations	Donor support and fund availability
Key stakeholders	MoPH, UN agencies and BPHS/EPHS implementers.
Implementing agency(ies)	MoPH, UN agencies and BPHS/EPHS implementers.
Indicator(s) (Data Source):	National FP guidelines update Number of master trainers and service providers trained on revised guideline
Future PPFP Program 2:	
Advocacy for integration of PPFP activities in to existing health system	
Activity 1:	Organize advocacy meetings and workshops to include updated PPFP methods in to BPHS/EPHS.
Timeframe	2016
Evidence of success	Meetings and workshops reports
Total cost over timeframe	10,000
Additional considerations	Political Commitment, Donor Support
Key stakeholders	MoPH, USAID, EU, WB, UN agencies, MSI and BPHS implementers
Implementing agency(ies)	MoPH and BPHS/EPHS Implementing NGOs
Activity 2:	Ensure provision of FP comodities at Health Facility and Health Posts level
Timeframe	2016-2020
Evidence of success	HMIS, monitorings and pharmacy stock reports
Total cost over timeframe	TBD
Additional considerations	Political Commitment and stability, Donor Support
Key stakeholders	MoPH, USAID, EU, WB, UN agencies, MSI and BPHS implementers

Implementing agency(ies)	MoPH and BPHS/EPHS Implementing NGOs
Activity 3:	Strengthen Monitoring and Evaluation system of PPFP activities at national and provincial level at both public and private sectors.
Timeframe	2016-2020
Evidence of success	monitoring reports
Total cost over timeframe	250000
Additional considerations	Political Commitment and stability, Donor Support
Key stakeholders	MoPH, USAID, EU, WB, UN agencies, MSI and BPHS implementers
Implementing agency(ies)	MoPH and BPHS/EPHS Implementing NGOs
Indicator(s) (Data Source):	Number of Health Facililites visited Number of monitoring reports received
Future PPFP Program 3:	
Demond generation activities (IEC/BCC) for PPFP at public, private and community level improved	
Activity 1:	Develop/distribute IEC/BCC materials for wider use of PPFP at facility and community level
Timeframe	2015-2017
Evidence of success	IEC/BCC materials
Total cost over timeframe	500,000
Additional considerations	Political Commitment and stability, Donor Support
Key stakeholders	MoPH, USAID, EU, WB, UN agencies, MSI and BPHS implementers
Implementing agency(ies)	MoPH and BPHS/EPHS Implementing NGOs
Activity 2:	Advocacy campaign through mass media and civil socisty
Timeframe	2016-2020
Evidence of success	Messages reached communities and utilization increased. (Routine health system and survey reports).
Total cost over timeframe	200,000
Additional considerations	Political Commitment and stability, Donor Support
Key stakeholders	MoPH, USAID, EU, WB, UN agencies, MSI and BPHS implementers
Implementing agency(ies)	MoPH and BPHS/EPHS Implementing NGOs

Activity 3:	**Oreintation sessions for community/religious leaders, FHAG, schools teachers, media and civil society on PPFP**
Timeframe	**2015-2020**
Evidence of success	**Meeting and events reports**
Total cost over timeframe	**200,000**
Additional considerations	**Political Commitment and stability, Donor Support**
Key stakeholders	**MoPH, USAID, EU, WB, UN agencies, MSI and BPHS implementers**
Implementing agency(ies)	**MoPH and BPHS/EPHS Implementing NGOs**
Indicator(s) (Data Source):	**Number of IEC/BCC materials developed, broadcasted and distributed** **Number of community elders, religious leaders and teachers trained**

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Country:	Afghanistan	Country Coordinator:	Dr. Rasheda Formuli

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:	**National FP guideline on recent MEC updated and implemented.**			
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		
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?		No	
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		But the expectation of the MoPH is to provide services at the country level. While there is no resources available to increase national level coverage.
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		

	Scale-up Consideration	Yes	No	More Information/Action Needed
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		The designed activities are based norms and values of sociocultural context of the country.
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?		No	As Afghanistan is donor dependant country it will need resource mobilization and donor support.
16	Will the financing of the program be sustainable?		No	Based on donor support and dependency the programme might not 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?	Yes		Based on Afghanistan health service provision strategy, health services are contracted out to NGOs, and MoPH is having a steward and leadership role. So, The PPFP program scale up need to be tested to find ways for proper scale up.
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?		No	There are few steps and system in place i.e. HMIS and national M&E system at MoPH level, but they are not capturing the health outcomes in a systimatic way. Some surveys have been done i.e. AMS, NRVA and AHS that are documenting the health outcomes and recently a first DHS of Afghanistan has been undertaken but the report is still to be available.
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		

	Scale-up Consideration	Yes	No	More Information/Action Needed
21	Does the program include mechanisms to review progress and incorporate new learning into its implementation process?	Yes		The system of review is in place but at the projects level, the MoPH need to support this practice at the national progamme level.
22	Is there a plan to share findings and insights from the program during implementation?	Yes		The system of review is in place but at the projects level, the MoPH need to support this practice at the national progamme level.
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		The system of review is in place but at the projects level, the MoPH need to support this practice at the national progamme level.
	Scale-up Consideration	**Yes**	**No**	**More Information/Action Needed**
Future PPFP Program 2:	**Advocacy for integration of PPFP activities in to existing health system**			
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		
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?		No	
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 stakholder expectations for where and to what extent activities are to be scaled-up?	Yes		But the expectation of the MoPH is to provide services at the country level. While there is no resources available to increase national level coverage.
9	Does the program identify and take into consideration community, cultural and gender factors that might constrain or support its implementation?	Yes		

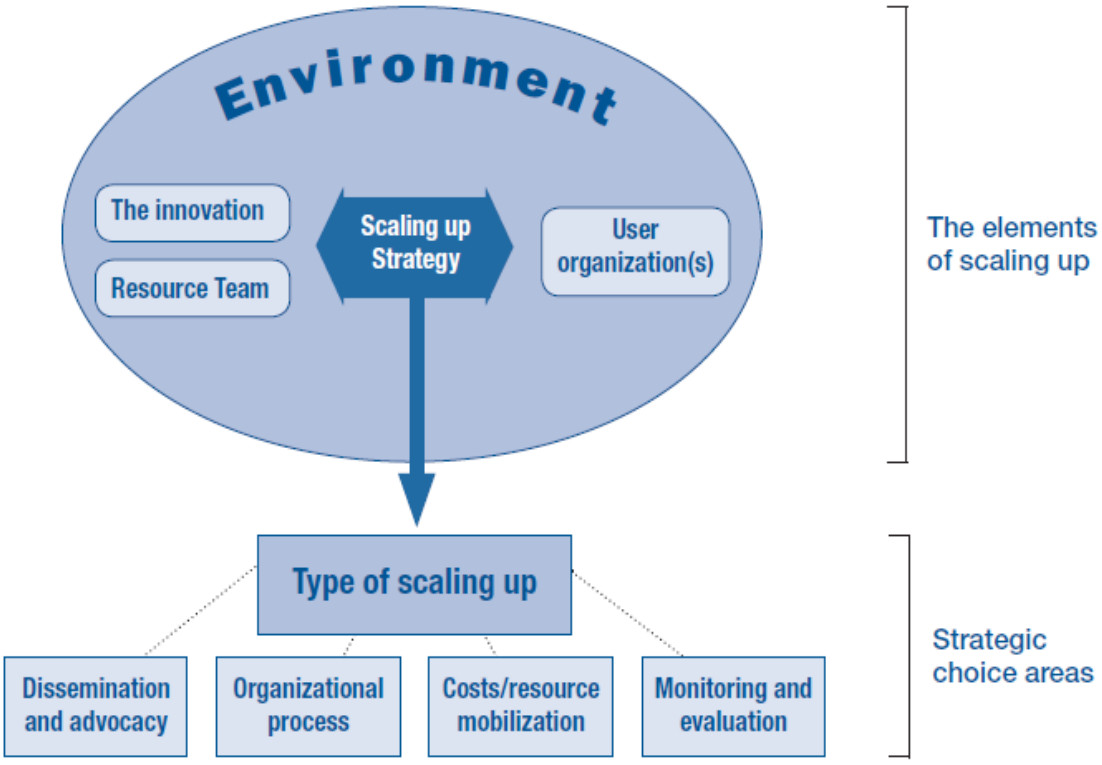
	Scale-up Consideration	Yes	No	More Information/Action Needed
10	Have the norms, values and operational cultrue of the implementing agency(ies) been taken into account in the program's design?	Yes		
11	Have the opportunities and constraints of the political, policy, health-sector and other institutional 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		The designed activities are based norms and values of sociocultural context of the country.
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?		No	As Afghanistan is donor dependant country it will need resource mobilization and donor support.
16	Will the financing of the program be sustainable?		No	Based on donor support and dependency the programme might not 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?	Yes		Based on Afghanistan health service provision strategy, health services are contracted out to NGOs, and MoPH is having a steward and leadership role. So, The PPFP program scale up need to be tested to find ways for proper scale up.
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?		No	There are few steps and system in place i.e. HMIS and national M&E system at MoPH level, but they are not capturing the health outcomes in a systimatic way. Some surveys have been done i.e. AMS, NRVA and AHS that are documenting the health outcomes and recently a first DHS of Afghanistan has been undertaken but the report is still to be available.
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		

	Scale-up Consideration	Yes	No	More Information/Action Needed
20	Are there plans to advocate for changes in policies, regulations and other health-systems components needed to institutionalize the program?	Yes		
21	Does the program include mechanisms to review progress and incorporate new learning into its implementation process?	Yes		The system of review is in place but at the projects level, the MoPH need to support this practice at the national progamme level.
22	Is there a plan to share findings and insights from the program during implementation?	Yes		The system of review is in place but at the projects level, the MoPH need to support this practice at the national progamme level.
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		The system of review is in place but at the projects level, the MoPH need to support this practice at the national progamme level.
	Scale-up Consideration	**Yes**	**No**	**More information/action needed**
Future PPFP Program 3:	**Strengthen Monitoring and Evaluation system of PPFP activities at national and provincial level at both public and private sectors.**			
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		
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?		No	
7	Is the program consistent with existing national health policies, plans and priorities?	Yes		

	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?	Yes		But the expectation of the MoPH is to provide services at the country level. While there is no resources available to increase national level coverage.
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 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		
12	Have the activities for implementing the program been kept as simple as possible without jeopardizing outcomes?	Yes		The designed activities are based norms and values of sociocultural context of the country.
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?		No	As Afghanistan is donor dependant country it will need resource mobilization and donor support.
16	Will the financing of the program be sustainable?		No	Based on donor support and dependency the programme might not 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?	Yes		Based on Afghanistan health service provision strategy, health services are contracted out to NGOs, and MoPH is having a steward and leadership role. So, The PPFP program scale up need to be tested to find ways for proper scale up.
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?		No	There are few steps and system in place i.e. HMIS and national M&E system at MoPH level, but they are not capturing the health outcomes in a systimatic way. Some surveys have been done i.e. AMS, NRVA and AHS that are documenting the health outcomes and recently a first DHS of Afghanistan has been undertaken but the report is still to be available.

	Scale-up Consideration	Yes	No	More Information/Action Needed
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		The system of review is in place but at the projects level, the MoPH need to support this practice at the national progamme level.
22	Is there a plan to share findings and insights from the program during implementation?	Yes		The system of review is in place but at the projects level, the MoPH need to support this practice at the national progamme level.
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		The system of review is in place but at the projects level, the MoPH need to support this practice at the national progamme level.

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:	Afghanistan	Country Coordinator:	Dr. Rasheda Formuli

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	Oreintation to RHD at MoPH on new initiatives on PPFP 2020	Dr. Jalil	Dr. Rasheda	End of June	NA
2	Oreintation to Jhpiego staff in Afghanistan on new innitiatvies on PPFP 2020	Dr. Farid	NA	End of June	NA
3	Oriantation to FP technical working group members and Reproductive Health Taskforce	Dr. Rasheda	Dr. Jalil	July	NA
4	Making PPFP a main part of the national FP consultative workshop	Dr. Farid	Dr. Jalil	July	NA
5	Oreintation to MSI staff in Afghanistan on new innitiatvies on PPFP 2020	Dr. Roshani	NA	End of June	NA
6	Establishment of technical working group to revise/update FP guideline based on recent MEC	Dr. Rasheda	Dr. Jalil	End July	NA
7	Train master trainers based on recent MEC	Dr. Rasheda	Dr. Jalil	During September	
8	Develop IEC/BCC materials for PPFP	Dr. Farid will follow with HEMAYAT project and HPD/MoPH	Dr. Jalil	September	
9	Print and distribute IEC/BCC materials	Dr. Jalil	Dr. Farid	October	
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					