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.

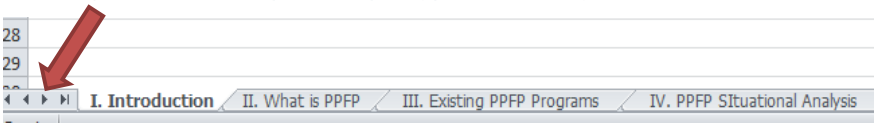
(4) For each of the future PPFP programs, complete a detailed PPFP Implementation Plan and consider how each program can best be scaled up to reach national and global family planning goals.

(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]

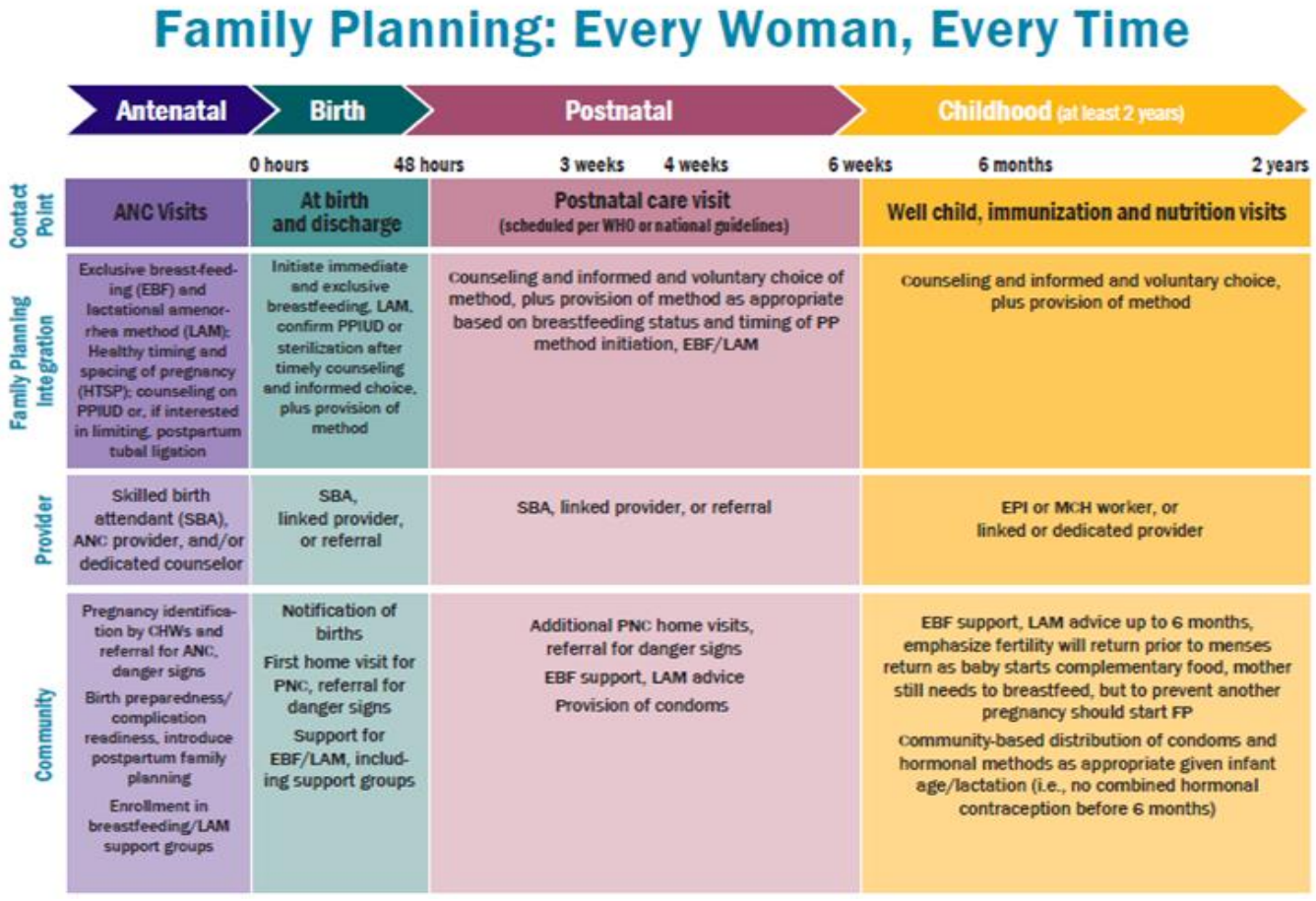
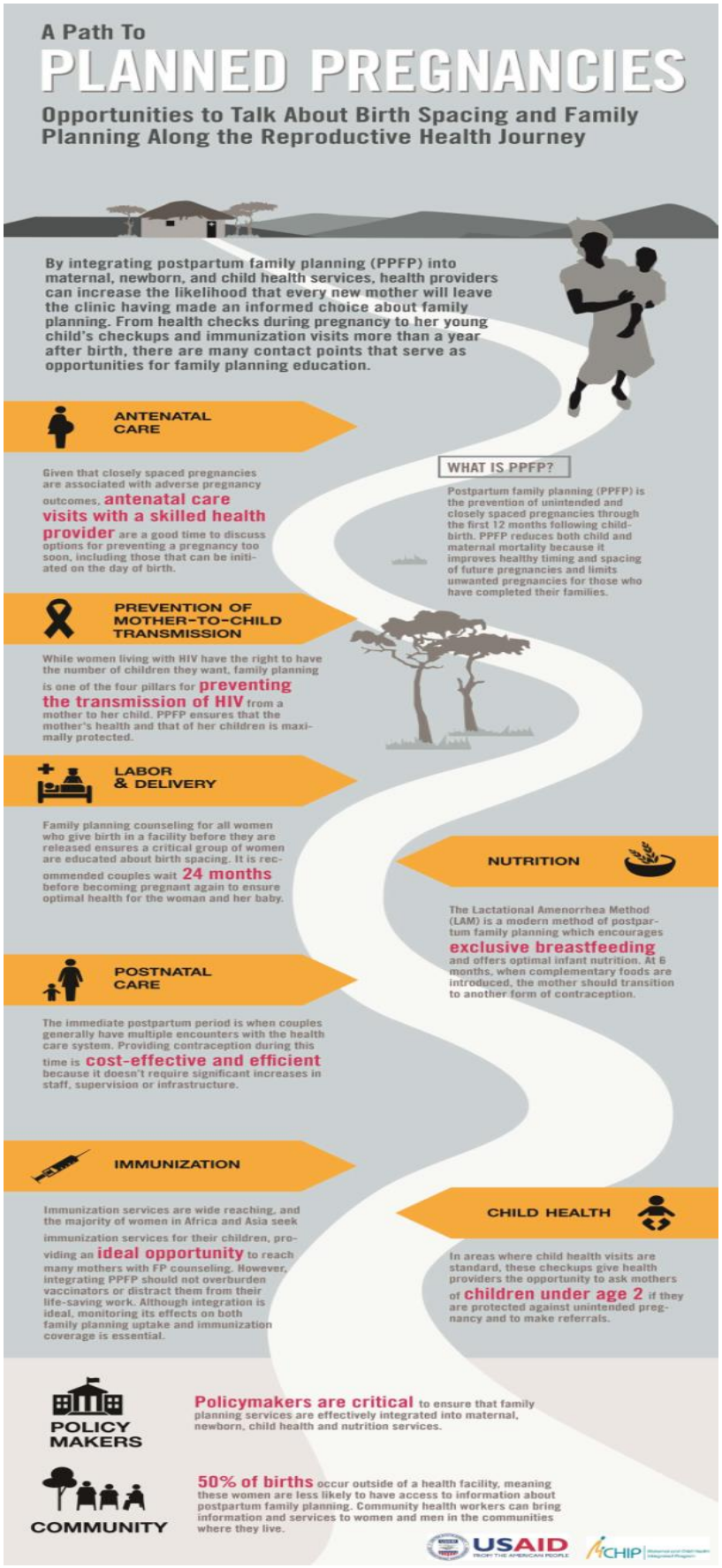


Figure 2. PPFP Integration Opportunities [MCHIP 2013]



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Country:	Indonesia	Country Coordinator:	Mona Saragih

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:	**Improving Acess and Quality of Postpartum Family Planning**
Activity 1:	**Trainning for PPFP focus on PPIUD**
Timeframe	**2013 until 2019**
Evidence of success	**30 province have Qualified Facilitator**
Total cost over timeframe	-
Has this activity been scaled? Why or why not?	**Yes, for a few Province**
Key stakeholders	**DHO, Hospital, National Clinical Trainning Networking, POGI, IBI and BKKBN**
Implementing agency(ies)	**MoH**
Activity 2:	**Provide The PPFP Books**
Timeframe	**from 2015 - 2016**
Evidence of success	**Every Facility have PPFP Books**
Total cost over timeframe	
Has this activity been scaled? Why or why not?	**On going**
Key stakeholders	**MoH and DHO**
Implementing agency(ies)	**Hospital and Community Health Center**
Activity 3:	**Monitoring PPFP Services Trough an Recording and Reporting Integrated System From Community Health Services**
Timeframe	**Ongoing countinous**
Evidence of success	**District - Province - National Report monthly**
Total cost over timeframe	

Has this activity been scaled? Why or why not?	Ongoing countinous
Key stakeholders	DHO, Community Health Services
Implementing agency(ies)	Community Health Services
Indicator(s) (Data Source):	Increasing the number of Services PPFP (Ministry Of Health Indonesia)
Existing PPFP Program 2:	Pilihanku (My Choice) Program
Activity 1:	Identify and Train full Time dedicated PPFP Councelor and provider
Timeframe	Oktober 2014 - September 2015
Evidence of success	34 Facility in 11 District have a full time PPFP Councelor
Total cost over timeframe	
Has this activity been scaled? Why or why not?	Starting now
Key stakeholders	MoH, BKKBN, DHO, Hospital, Jhpiego, JHU CCP, JSI, UGM (avenir), DKT Andalan
Implementing agency(ies)	MoH, BKKBN, DHO, Hospital, Jhpiego, JHU CCP
Activity 2:	Demand Creation
Timeframe	July 2015 - 2017
Evidence of success	Campaign materials distribute and aired
Total cost over timeframe	$500,000.00
Has this activity been scaled? Why or why not?	will started at scale
Key stakeholders	BKKBN, JHCCP, DKT
Implementing agency(ies)	BKKBN, JHCCP, DKT
Activity 3:	On The Job Trainning for facilites providers
Timeframe	2015 - 2017
Evidence of success	Every provider can do the PPFP focus on PPIUD and Implant
Total cost over timeframe	
Has this activity been scaled? Why or why not?	not yet, plan start end of 2015
Key stakeholders	MoH, DHO, BKKBN and Jhpiego
Implementing agency(ies)	MoH, DHO, BKKBN and Jhpiego
Indicator(s) (Data Source):	Double number of PPFP acceptors from 5% to 10% at participating facilities (facility and program reporting)

Existing PPFP Program 3:	Hospital Family Planning Program focus on PPFP and Post Abortion
Activity 1:	provide the contraceptive method, equipment, Job Aids, recording and reporting dan monitoring
Timeframe	Ongoing countinous
Evidence of success	every Hospital has a PPFP method and equipment
Total cost over timeframe	
Has this activity been scaled? Why or why not?	Yes
Key stakeholders	BKKBN
Implementing agency(ies)	
Activity 2:	FP Counseling and Service Provision Trainning
Timeframe	Ongoing countinous
Evidence of success	all labour and delivery provider health workers in Hospital was trained
Total cost over timeframe	
Has this activity been scaled? Why or why not?	Yes
Key stakeholders	BKKBN, MoH, Hospital
Implementing agency(ies)	BKKBN, MoH, Hospital
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)	251,452,000	Population that will benefit from families reaching desired size
2	Annual population growth, %	Population Reference Bureau "Rate of Natural Increase" (see Tab IX)	1.4	Pace of population change that could be slowed with PPFP
3	Crude birth rate	Population Reference Bureau (see Tab IX)	20/1,000	Numbers of births occurring
4	Number of women of reproductive age (WRA)	Population Reference Bureau (see Tab IX)	66,900,000	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)	5,029,040	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)	2.6	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)	42/1,000	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)	>17 month 4%, >23 months 6%, 14% >35 months13% >47 months	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)	25-29= 22.8% 30-34=22%	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)	11.40%	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 4.4 and limiting 7	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	12,1 % (Mini Survey in 2009, BKKBN)	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)	married women 58 mCPR	Population of women who are currently using family planning
15	Your country's CPR target	Government website or other publicly available reference	62 mCPR	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)	35% short-acting, 7.2% longacting 0 LAM permanent 3.5%	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)	81	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)	48 then 11	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)	63	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)	36	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		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	1). 0 - 1 day : 31,3%, 2). 2 days : 10,4 %, 3). 3-7 days : 22,8%, 4). 8 - 42 days : 4,4%, 5). >42 days : 1.0% (Mini Survey, 2009 from BKKBN)	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)	1) BCG : 77,9%, 2) DPT 3 : 61,9% (Basic Health Research, 2010) 1). BCG : 89%, 2). DPT : 80%, 3). DPT3 : 71% (Indonesian Health Demographic Survey, 2012)	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]	1). TBA : 12,2%, 2) by her self 49,4%, 3). Others : 6,1% (Basic Health Research, 2010)	Population that is at high maternal mortality risk and is likely to need postabortion care, including FP services
GOVERNANCE DATA				
26	FP2020 Commitment	http://www.familyplanning2020.org/reaching-the-goal/commitments		Country-level, public financial commitment to invest in FP
27	Statement for Collective Action for PPFP Country Endorsement	http://www.mchip.net/actionppfp/		Country-level, public support/champions for PPFP
28	National FP Strategy	Government website or other publicly available citation		Where PPFP should be included or enhanced to affect national policy
29	FP Costed Implementation Plan	Government website or other publicly available citation		Where PPFP programs with budgets should be included or enhanced to affect national policy

	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	provider cadres must standarized and competency based	

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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:	**Improving Acess and Quality of Postpartum Family Planning**

	Health System Dimension	**Strenths**	**Weaknesses**	**Opportunities**	**Threats**
I	Health Services				
	a. Public sector			Revised MEC 2015	Possibility of contradicting policies/regulations at the district vs. provincial vs national level
		Established primary health care system	Distribution and quality of health providers	Possible integration with Immunization	
			Isolated geographical areas	Coordination between MoH and BKKBN	
	b. Faith-based/non-governmental organization (NGO)	Most FBOs/NGOS pro FP policies and regulations		MUI -(Muslim reference group) to speak favorable about PPFP	Growing religious conservatism
		Many are well respected religios groups, the largest Muslim orgs in the world			
	c. Private sector	70% of FP services obtained in private secto	Private sector provide mostly pill and injections	There are a lot of services, and they provide birthing facilities	Lack of clarification on how National Health Insurance will affect private sector
			Provider bias agains LARCs		

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
2	Health management information system (HMIS)	There is a system in place at all levesl of services	Validity of data	Use of ICT due to data online	There are two systems for data collection between MoH and BKKBN, double entry of forms requires extra work
3	Health workforce	Health Providers : Population ratio has met WHO standard	Not All Health Workers (OBGYN and Midwife) sosialization about PPFP and PPIUD	National regulations to support quality FP services in place	
4	Medicines and technology	Choice of methods	Weak in logistic management with stockouts at facilities and private pharmacies	Health Technological Assessment for Implant (ORA)	Quality of some commodites and leakage of commodoties
5	Health financing	FP included in the new Universal Health Coverage. Local health insurance	Lack of knowledge of Universal Health Coverage at all levels. Referral system not well established	Political will at the highest levels,. Private sector engaged in UHC	Midwives feel uncertain about joining UHC, increased burden and cost benefit not clear. UHC only cover facility based services (exclude mobile services)
6	Leadership and governance	Political will at national and province levels	disconected leadership between central and local government		Political will in some provinces and districts (pro natalist policies)
7	Community and sociocultural				
	a. Community-based	Cader Community	Culture in Indonesia : Post partum woman should not leave house before 40 days	Home visit for postpartum woman and Baby	
			Significant reduction of FP field workers		
	b. Mobile outreach	Mobile Family Teams establsihed and providing services at district level	Lack of finincial support from local government	FP Mobile services based at the district level (especially for PPFP)	
	c. Social marketing				
Existing PPFP Program 2:		**Pilihanku (My Choice) Program**			
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:		**Hospital Family Planning Program focus on PPFP and Post Abortion**			
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:	Indonesia	Country Coordinator:	

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:	
PPFP in the Continuum of Care	
Activity 1:	**Bridging Community and Services through Community Quality Engagement**
Timeframe	**2016 - 2018**
Evidence of success	**Number of health facilities that have Community Quality Engagement plans with their community**
Total cost over timeframe	**??**
Additional considerations	**This will be started in a numebr of facilities and then scaled up if successful. This can be tied into the MyChoice ongoing program**
Key stakeholders	**BKKBN, MoH, Local Health Facilities, District Leaders, community leaders**
Implementing agency(ies)	**BKKBN, MyChoice Team, DinKes**
Activity 2:	**Demand Creation for PPFP**
Timeframe	**2015-2017**
Evidence of success	**Numebr of women who have heard or seen PPFP messages**
Total cost over timeframe	**US$ 2,000,000**
Additional considerations	**There will be ongoingFP campaighs, and PPFP will need to be added as a com,ponent**
Key stakeholders	**BBKN, MoH, MyChoice**
Implementing agency(ies)	**BKKBN,MyChoice**

Activity 3:	**Community Outreach for PPFP**
Timeframe	**2015-2017**
Evidence of success	**% of pregnant women who have been reached by a community FP Volunteer**
Total cost over timeframe	**US$500,000**
Additional considerations	**Ther are a number of different Community Mobilization programs being implemented through BKKBN, MoH, and community level providers. These need to be harnessd and provided tools and message. One tool is an electronic tablet for counseling**
Key stakeholders	**BKKBN, DinKKes, health facilities, MyChoice, UNFPA**
Implementing agency(ies)	**BKKBN, MyChoice, DinKes**
Indicator(s) (Data Source):	**% of pregnant women who have chosen a method before delivery, and is using it postpartum**
Future PPFP Program 2:	
Health Provider Capacity Building and Supply	
Activity 1:	**On The Job Trainning of PPFP**
Timeframe	**July 2015 - 2016**
Evidence of success	**Increase of PPFP Services**
Total cost over timeframe	
Additional considerations	**Additional Competency of Health Provider to share the knowledge and skill with their collegue in the facility and demand generation**
Key stakeholders	**DHO, FP District Office**
Implementing agency(ies)	**Head of Facility**
Activity 2:	**Mentoring and Coaching and Post Training Follow Up**
Timeframe	**July 2015 - 2016**
Evidence of success	**PPFP Technical Criteria achieved by providers and facilities and Increased skill retention of PPFP**
Total cost over timeframe	
Additional considerations	**Additional work load for the Mentor or Coach and Inaddequate number of trainer relative to the trainee**
Key stakeholders	**DHO, FP District Office, FP & RH Trainning Center, DHO and Province FP Office**
Implementing agency(ies)	**Head of Facility, FP&RH Trainning Center**
Activity 3:	**Strengthening FP services through the establishment of "Track and Trace ICT application" programme**
Timeframe	**2016-2018**

Evidence of success	% of women who delivered are being followed up
Total cost over timeframe	$600,000
Additional considerations	Need to adapt the IT tools being developed to accomopdate the system
Key stakeholders	BKKBN, MoH, UNFPA, Partner Organizations
Implementing agency(ies)	BKKBN, MoH, UNFPA, Partner Organizations
Indicator(s) (Data Source):	Increased number of wome leaving the facility with a PPFP method
Future PPFP Program 3:	
Enabling Environment	
Activity 1:	Refocusing of PPFP in the existing FP policies/guidelines/job aids
Timeframe	June-September 2015
Evidence of success	PPFP is boldly reflected in at least in Rights Based FP Strategy
Total cost over timeframe	IDR 100,000,000
Additional considerations	To get the National Planning Agency (BAPPENAS) to own the document and further include the strategy in the National Annual Plans.
Key stakeholders	MOH; BAPPENAS; MOHA
Implementing agency(ies)	BKKBN
Activity 2:	Provincial and District Advocacy for PPFP
Timeframe	2015-2016
Evidence of success	Committed financial and human resources for PPFP at the District Level
Total cost over timeframe	
Additional considerations	This activitie can be added to the ongoing Kb Kencana program
Key stakeholders	BKKBN, MOH, DinKes
Implementing agency(ies)	BKKBN,MOH
Activity 3:	Idntify and recruit PPFP chanpions
Timeframe	July 2015-June 2016
Evidence of success	High Level and well Knoen champions recruited and getting PPFP on the national and local agenda
Total cost over timeframe	IDR200,000,000

Additional considerations	**To succeed there neds to be well known and liked Champions and also practical champions for the technical side**
Key stakeholders	**BKKBN,MoH, Indonesia's Fisrt Lady**
Implementing agency(ies)	**BKKBN, MoH, MyChoice**
Indicator(s) (Data Source):	**Implementation plan agreed upon and costed.**

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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?	x		
2	Are individuals from the implementing agency(ies) involved in the program's design and implementation?	x		
3	Does the program have mechanisms for building ownership in the implementing agency(ies)?	x		
4	Does the program address a persistent health or service delivery problem?	x	x	
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?		x	
7	Is the program consistent with existing national health policies, plans and priorities?	x		
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?	x		
9	Does the program identify and take into consideration community, cultural and gender factors that might constrain or support its implementation?	x		
10	Have the norms, values and operational culture of the implementing agency(ies) been taken into account in the program's design?	x		
11	Have the opportunities and constraints of the political, policy, health-sector and other institutional factors been considered in designing the program?	x		

	Scale-up Consideration	Yes	No	More Information/Action Needed
12	Have the activities for implementing the program been kept as simple as possible without jeopardizing outcomes?	?		
13	Is the program being implemented in the variety of sociocultural and geographic settings where it will be scaled up?		x	
14	Is the program being implemented in the type of service-delivery points and institutional settings in which it will be scaled up?	x	x	
15	Does the program require human and financial resources that can reasonably be expected to be available during scale-up?	x		
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?	x		
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?			
19	Is there provision for early and continuous engagement with donors and technical partners to build a broad base of financial support for scale-up?			
20	Are there plans to advocate for changes in policies, regulations and other health-systems components needed to institutionalize the program?			
21	Does the program include mechanisms to review progress and incorporate new learning into its implementation process?			
22	Is there a plan to share findings and insights from the program during implementation?			
23	Is there a shared understanding among key stakeholders about the importance of having adequate evidence related to the feasibility and outcomes of the program prior to scaling up?			

Scale-up Consideration	Yes	No	More Information/Action Needed
Future PPFP Program 2:			

	Scale-up Consideration	Yes	No	More Information/Action Needed
1	Is input about the program being sought from a range of stakeholders?			
2	Are individuals from the implementing agency(ies) involved in the program's design and implementation?			
3	Does the program have mechanisms for building ownership in the implementing agency(ies)?			
4	Does the program address a persistent health or service delivery problem?			
5	Is the program based on sound evidence and preferable to alternative approaches?			
6	Given its financial and human resource requirements, is the program feasible in the local settings where it is to be implemented?			
7	Is the program consistent with existing national health policies, plans and priorities?			
8	Is the program being designed in light of agreed-upon stakholder expectations for where and to what extent activities are to be scaled-up?			
9	Does the program identify and take into consideration community, cultural and gender factors that might constrain or support its implementation?			
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?			

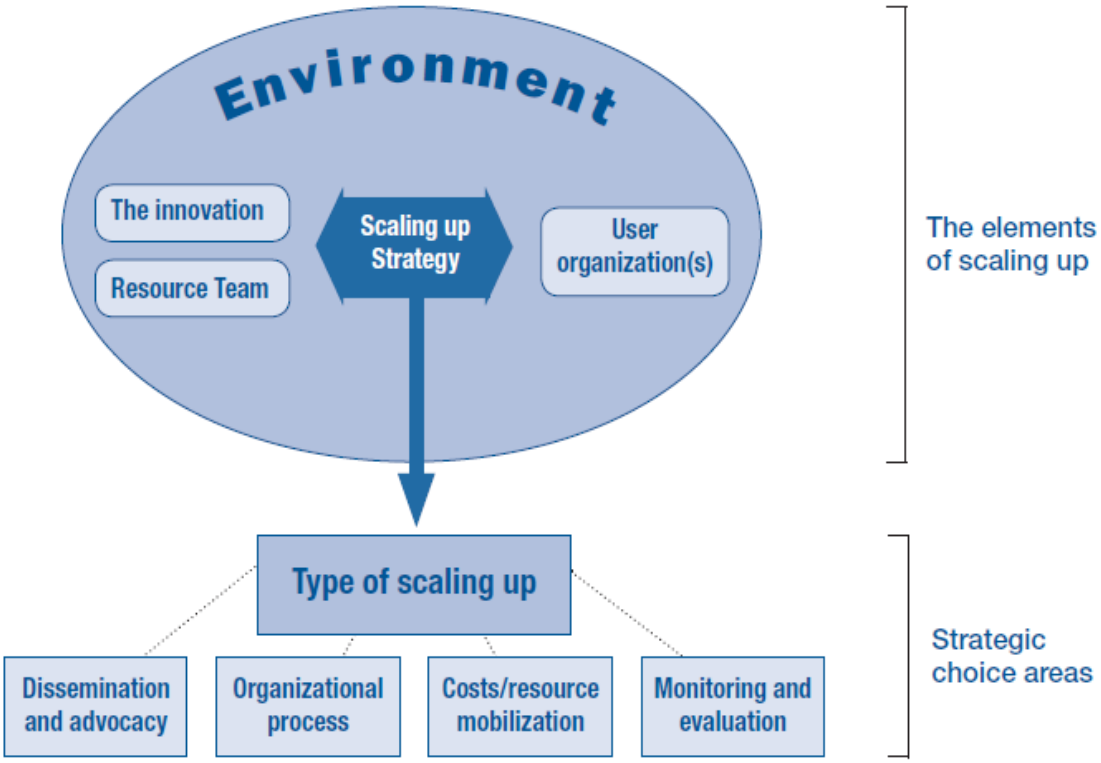
	Scale-up Consideration	Yes	No	More Information/Action Needed
15	Does the program require human and financial resources that can reasonably be expected to be available during scale-up?			
16	Will the financing of the program be sustainable?			
17	Does the health system currently have the capacity to implement the program? If not, are there plans to test ways to increase health-systems capacity?			
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?			
19	Is there provision for early and continuous engagement with donors and technical partners to build a broad base of financial support for scale-up?			
20	Are there plans to advocate for changes in policies, regulations and other health-systems components needed to institutionalize the program?			
21	Does the program include mechanisms to review progress and incorporate new learning into its implementation process?			
22	Is there a plan to share findings and insights from the program during implementation?			
23	Is there a shared understanding among key stakeholders about the importance of having adequate evidence related to the feasibility and outcomes of the program prior to scaling up?			

	Scale-up Consideration	Yes	No	More information/action needed
Future PPFP Program 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)?			

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

	Scale-up Consideration	Yes	No	More Information/Action Needed
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?			
19	Is there provision for early and continuous engagement with donors and technical partners to build a broad base of financial support for scale-up?			
20	Are there plans to advocate for changes in policies, regulations and other health-systems components needed to institutionalize the program?			
21	Does the program include mechanisms to review progress and incorporate new learning into its implementation process?			
22	Is there a plan to share findings and insights from the program during implementation?			
23	Is there a shared understanding among key stakeholders about the importance of having adequate evidence related to the feasibility and outcomes of the program prior to scaling up?			

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:	Indonesia	Country Coordinator:	

VIII. PPFP Action Plan

The PPFP Implementation Plan started in sheet VI. will have missing or temporary information that your country team needs to complete, and the final plan will also need to be adopted by all stakeholders and implementing agencies involved. In the table below, identify all remaining tasks and assign both a primary and secondary member of the team responsible for its execution by a given deadline.

	Task	Primary person responsible	Secondary person responsible	Deadline	What problems do you anticipate? What will you do when you encounter these (or other) problems?
1	Briefing to Dr. Christine (Head of FP sub directorate - MOH)	Mona			
2	Report of the 'Chiang Mai' team to : 1. Chairperson of BKKBN 2. DG of NMCH - MOH	1. Dr. Irma 2. Prof Biran	Mona	week 3 June 2015	conflicting time of the officials
3	Prepare Briefing Kit for the engament meeting : packaging of evidence	Rob	Rury Mela	Jun-15	
4	Courtessy Call to the Minister of Health	Prof Biran		4th week of June 2015	
5	Series of meeting of the PPFP technical team: prepare the National meeting; Terms of Reference; prepare draft outputs of meeting	1. Dr. Irma (coordinator) 2. Dr. Christine		June - July 2015	
6	National meeting for accelerating access to and quality of PPFP. Expected Outputs: 1. Concensus of key stakeholders: a. Revise the Guideline on PPFP and Hospital based FP services (PKBRS); with agreement to have legal basis for their used. b. Inclussion of the PPFP in the Rights Based FP Strategic Framework and the Male Involvement Strategy c. Revise Health Technoloy Assessment for PPFP d. Revise Job Aid MEC wheel 2. Agreed Action Plan towards the compleetion of the above	Dr. Irma (BKKBN) Dr Chistine (MOH)		Aug-15	Funding might be an issue as Government has not budgetted the fund for the activity. BKKBN could anticipate to encourage its Provincial Offices to support funding for provincial participants. Other possible funding: My CHOICE & UNFPA

	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	Follow up of the National Meeting (Concensus follow up): a. Revise the Guideline on PPFP and Hospital based FP services (PKBRS); with agreement to have legal basis for their used. b. Inclussion of the PPFP in the Rights Based FP Strategic Framework c. Revise Health Technoloy Assessment for PPFP d. Revise Job Aid MEC wheel	Dr. Irma (BKKBN) Dr Chistine (MOH)	a. Prof Biran & Christine b. Irma & Mela c. Dr. Arietta & BA d. Rury & Rob	Aug-Oct 2015	
8					
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	Task	Primary person responsible	Secondary person responsible	Deadline	What problems do you anticipate? What will you do when you encounter these (or other) problems?
18					
19					
20					