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.

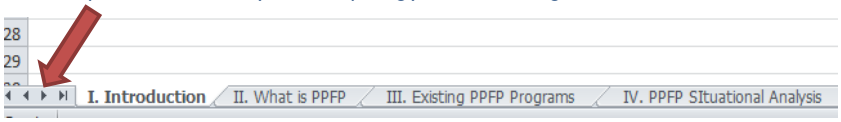
(4) For each of the future PPFP programs, complete a detailed PPFP Implementation Plan and consider how each program can best be scaled up to reach national and global family planning goals.

(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]

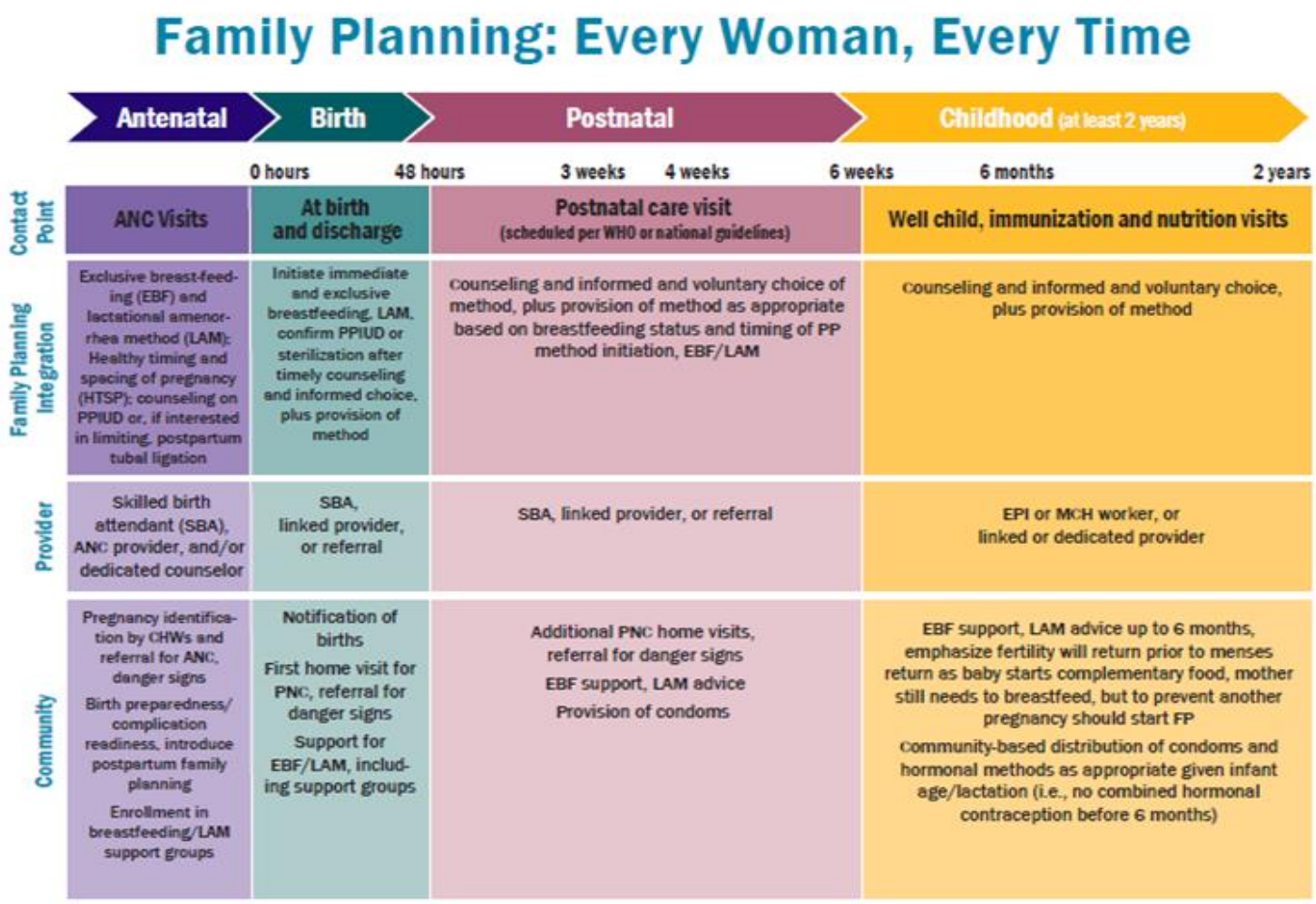
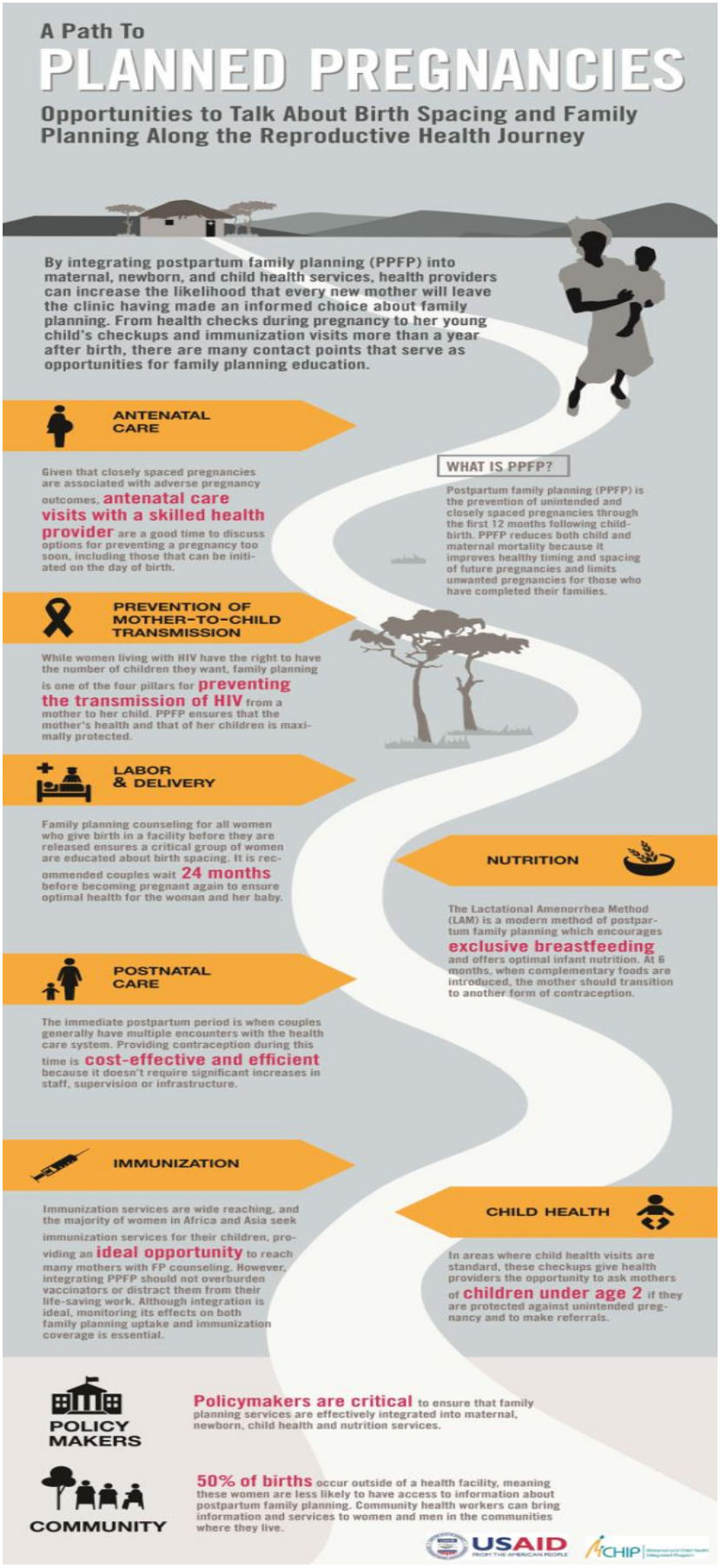


Figure 2. PPFP Integration Opportunities [MCHIP 2013]



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Country:	Tanzania	Country Coordinator:	Maurice Hiza

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:	**Post-partum Care (MCH)**
Activity 1:	**Develop National Guidelines and Training curriculum**
Timeframe	**2010-2012**
Evidence of success	**Guidelines are available and is being used Nationally by MOHSW, PMORALG and Development partners**
Total cost over timeframe	**XX**
Has this activity been scaled? Why or why not?	**Yes, has been distributed nation-wide. Needs to be reviewed.**
Key stakeholders	**MOHSW, PMORALG and Development partners (JHPIEGO, EngenderHealth, MST, PSI, WHO, UNICEF, UNFPA)**
Implementing agency(ies)	**MOHSW & PMORALG, FBO with support from and Development partners**
Activity 2:	**Training of Trainers and Service providers**
Timeframe	**Ongoing**
Evidence of success	**(To be determined) service providers trained**
Total cost over timeframe	**XXX**
Has this activity been scaled? Why or why not?	**(To be determined) Trainings are ongoing**
Key stakeholders	**MOHSW, PMORALG & Development partners (JHPIEGO, EngenerHealth, MST, PSI, WHO, UNICEF, UNFPA)**
Implementing agency(ies)	**MOHSW, PMORALG and Development partners (JHPIEGO, EngenderHealth, MST, PSI)**
Activity 3:	**Postpartum care services are being provided**
Timeframe	**2012-present**
Evidence of success	**(RMNCH scorecard)**
Total cost over timeframe	**XXX**

Has this activity been scaled? Why or why not?	Throughout the country
Key stakeholders	MOHSW, PMORALG & Development partners
Implementing agency(ies)	MOHSW, PMORALG & Development partners
Indicator(s) (Data Source):	
Existing PPFP Program 2:	Postpartum Family Planning
Activity 1:	Develop PPFP Training Resource Package*
Timeframe	2013-present (*currently under development)
Evidence of success	Has been pre-tested in 3 Regions
Total cost over timeframe	XXX
Has this activity been scaled? Why or why not?	Will be scalled once finalized and aproved
Key stakeholders	MOHSW, EngenderHealth, AGOTA, JHPIEGO, PSI, MST
Implementing agency(ies)	MOHSW, EngenderHealth, JHPIEGO
Activity 2:	Development of PP-IUCD curriculum
Timeframe	2013
Evidence of success	Curriculum not yet finalized, pre-tested, trainers and providers trained
Total cost over timeframe	XXX
Has this activity been scaled? Why or why not?	Trainers and providers will be trained once curriculum is finalized
Key stakeholders	MOHSW, JHPIEGO, EngenderHeatlh, PSI
Implementing agency(ies)	MOHSW, JHPIEGO, EngenderHeatlh, PSI, Pathfinder, AGOTA, Royal College of Gyn.
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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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)	45.0 Million	Population that will benefit from families reaching desired size
2	Annual population growth, %	Population Reference Bureau "Rate of Natural Increase" (see Tab IX)	2.70%	Pace of population change that could be slowed with PPFP
3	Crude birth rate	Population Reference Bureau (see Tab IX)	39.7	Numbers of births occurring
4	Number of women of reproductive age (WRA)	Population Reference Bureau (see Tab IX)	11.0 Million	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)	2,030,280	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)	5.4	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)	5	Compare with #6 on total fertility rate
8	Adolescent fertility rate	Population Reference Bureau (see Tab IX)	128	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)	5, 11, 40, 20	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)	1 (15-19), 20 (20-23), 19.6 (24-29), 20 (30-34)	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)	22.3	Population of women who do not want to become pregnant and who are not using family planning—levels above 10% suggest low effectiveness of family planning efforts
12	Percentage of unmet need for: ➢ spacing ➢ limiting	Demographic and Health Survey (see Tab IX)	limiting: 7; spacing; 15.5	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	62	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)	modern: 27.0	Population of women who are currently using family planning
15	Your country's CPR target	Government website or other publicly available reference	60%	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)	modern: 27.0, any method: 34.4, LARC: 2.9, PM: 3.5, SA: 20.9, traditional: 12.1	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)	64.4 (0-3 months), 18.1 (3-6 months)	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)	50	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)	49	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	32	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	not recorded in HMIS, has been revised to collect this information	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)	Immunization coverage (%) 2012, BCG: 99 Immunization coverage (%) 2012, DPT1: 99 Immunization coverage (%) 2012, DPT3: 92	Population that can be reached with PPFP methods at routine immunization visits or through referrals from these visits
24	OPTIONAL: Percentage of women who experience violence during pregnancy, childbirth or for using family planning	Possibly Demographic and Health Survey; if not, use other available data or estimations	No data	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]	No data	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	doubling the No. of FP users to 4.2 million by 2015 to reach a national CPR of 60% by 2020.	Country-level, public financial commitment to invest in FP
27	Statement for Collective Action for PPFP Country Endorsement	http://www.mchip.net/actionppfp/	singed	Country-level, public support/champions for PPFP
28	National FP Strategy	Government website or other publicly available citation	yes	Where PPFP should be included or enhanced to affect national policy
29	FP Costed Implementation Plan	Government website or other publicly available citation	Yes	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	Short acting: CHW, nurse/ midwife, clinician, doctors; Depo: nurse/midwife, clinician, doctor, IUD: nurse/ midwife, clinician, doctor; implant: nurse/ midwife, clinician, doctor; PM: clinician, doctor.	

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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:	**Post-partum Care (MCH)**			
Health System Dimension	**Strenths**	**Weaknesses**	**Opportunities**	**Threats**
1 Health Services				
a. Public sector	98% of pregnant women attend ANC	FP education is weakly covered in ANC	ANC is an opportunity to offer FP	Cultural believes and low male involvement
	50% of pregnant women deliver in the health facilities	Limited provision PPFP services	PPFP may be delivered to this population	Limited skilled HRH
	All public health facilities provide FP services	Routin long term and permanent methods service delivery to CEmONC facilities	Integration FP with other RMNCH services	Limited financial resources
b. Faith-based/non-governmental organization (NGO)	Estimated 40% of health services are delivered by FBO and NGO	Some FBO do not offer modern FP	Majority of FBO facilities are located in underserved areas	Challenge of retention HRH due inadequate financial resources
	Strong PPP in health service delivery	Charging fees	Provide other RH services	
		Limited skillled HRH	Trusted facilities	
c. Private sector	Strong PPP	Weak integration	Provide other RH services	Limited skilled HRH
		Expensive services to afford majority	Trusted facilities	Distegration of RH services based specialized private providers
		Limited skillled HRH		
2 Health management information system (HMIS)	The entire health service delivery sytem use national HMIS (MTUHA)	It is paper based data of which needs to be entered in electronic system at district level	Plan is underway to introduce electronic data capture at regional, distric and dissernated hospitals	Financial resources as the system depends largely on donor funding
3 Health workforce	Upward trend of pre service training enrolment, graduation, recruitment and deployment	Staff retention schemes is weak	Many districts are introducing local retention schemes	Staff turnover from rural, underserved areas, to urban

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
4	Medicines and technology	There is central procurement system of medicines and other commodities through MSD	Limited finance, overwhelming increased workload to MSD particularly in distribution health facilities	Existence of PPP	Donor dependence logistic system
5	Health financing	Existence of different financing system i.e. via national budget, health insurance schemes and donor contribution	National health budgent allocation dependent on external funding	Presence of clear national health policy documents including RMNCAH document guiding priority areas i.e. Health System Strategic Plan, One Plan etc	Weak forecasting
6	Leadership and governance	Free RMNCH services policy	Less than 15% of the Abuja declaration budget allocation of the national health budget	Increased political commitment to improve RMNCAH to reduce maternal and child deaths	Shifting prioritie based on political regime
7	Community and sociocultural				
	a. Community-based	Increased No. of secondary school and secondary school enrolment	Harmful norms about how many children women are meant to bear	Living semi urbanized villages	Low of male involvement
		Partnership of religious, community and Government leaders	Lack of education among women	One language of communication	Weak referral system
	b. Mobile outreach	Presence of outreach services through catchment areas	Lack of reliable transport system	Defined catchment are per health facility	Limited financing
		Program oriented mobile services e.g. regular mobile FP services	Weak incentives	Presence of multiple (local/foreign) partners conducting mobile outreach services	Non ideal equipment including transport for outreach services
	c. Social marketing	Presence of multiple media companies	Weak engagement of media	PPP strategy is in place	Weak financing
		Available communication strategy			
Existing PPFP Program 2:		**Postpartum Family Planning**			
Health System Dimension		**Strenths**	**Weaknesses**	**Opportunities**	**Threats**

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
1	Health Services				
	a. Public sector	Political commitment is strong	Inadequate Government financing for FP commodities	over 50% of women deliver in the health system (HMIS)	DPs withdraw to finance FP commodities
	a. Public sector	HMIS is in place	Weak accountability of service delivery system	Presence of strong programs e.g. U5 growth monitoring and immunization	
		FP Commodities are centrally procured and distributed to health facilties			
	b. Faith-based/NGO	Strong business approach governance	Weak HRH retention package	Presence strong PPP	Sustainability of service is weeak
		Efficiency in service delivery	Do not allow method mix than natural methods	Trust built to the community	
	c. Private sector	Strong business approach governance	Weak HRH retention package	Presence strong PPP	Sustainability of service is weeak
		Efficiency in service delivery	Profit realization limits utilization	Trust built to the community	
2	HMIS	Rolled out throughout the country to all facilities	Donor dependent and mainly paper based	Electronic system started by entering dat at district level (DHIS 2015), Plan DHS2 to start at hospitals.	Paper based is prone to errors and difficult in data retrieval
3	Health workforce	There is increased government enrolment and deployment of HRH	No induction system is in place for newly qualified workers	Presence of zonal training centres	Staff retention strategy is weak and rotation of HRH to other departments within the same facility
4	Medicines and technology	Strong TFDA that may register new products and presence of ILS gateway to track commodities	Inadequate financial Govt budget allocation to commodities	Presence of multiple partners supporting RMNCH strategy including procurement of FP commodities	Sudden withdrawal of partners in FP commodity procurement
5	Health financing	Governement budget allocation to MOHSW budget	Over years budget allocation to Health shows no upward ternd	Multiple DPs complementing Govt effort	Donor reliance budget

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
6	Leadership and governance	Strong political commitment	Weak managerial at different levels of service delivery	Launch of RMNCH Sharpened One Plan 2014-2015 addressded accountability in broad terms	Changes in political leadership
7	Community and Sociocultural				
	a. Community-based	Write up of community RH and CHW is underway	No CHW except for stop gap prepared by different programs	Study is underway to assess possibility of scaling up the scope of CHW to provide Depo provera injection	Most of existed CHW program were driven by DPs
		Development of curriculum for pre CHW training is ongoing	How to remunerate available stop gap CHW is a challenge	Regions where CHW was strong has also shown high CPR compared to others.	Professional association relactancy to scale up CHW scope of work
		There RMNCH CHW guideline	Available CHW allowed to mobilize, distribute condoms and OCPs only		
	b. Mobile outreach	The MOHSW work with partners to do mobile outreach services	Cost involved in mobile outreach services	Strong PPP	Most for the mobile outreach service are donor depend
		Presence of guidelines for mobile outreach services	Sustainability is a challenge		
	c. Social marketing	Condoms are widely socially marketed, but no other methods	Lack strong marketing strategy on RMNCH	Presence of multiple companies interested on supporting RMNCH	Lack of adequate for social marketing
		Existence of PPP strategy and a section responsible for PPP			

Existing PPFP Program 3:

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
1	Health Services				
	a. Public sector				
	b. Faith-based/NGO				
	c. Private sector				

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
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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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:	
Postpartum Care (PPC) Program	
Activity 1:	**Provide supportive policy environment by revising PPC guidelines&Training Manual to incorporate PPFP service delivery**
Timeframe	**2015-2020**
Evidence of success	**Training materials are in place**
Total cost over timeframe	**XXX no. of sessions to review, XXX no. of copies printed, XXX no. of disseminations**
Additional considerations	**Systematic dissemination of training manual from National, regional, districts to health facilities**
Key stakeholders	**MOHSW, PMORALG and DPs**
Implementing agency(ies)	**MOHSW, PMORALG&DPs**
Activity 2:	**Dissemination of guidelines to stakeholders and policy makers**
Timeframe	**2015-2020**
Evidence of success	**Guideline disseminated at national, regional and district/council level**
Total cost over timeframe	**XXX**
Additional considerations	**Demand creation/ awareness building around this intervention need to be considered.**
Key stakeholders	**MOHSW, PMORALG&DPs**
Implementing agency(ies)	**MOHSW, PMORALG&DPs**
Activity 3:	**Ensure commodity security (at service delivery point including labour ward postnatal room and immunition/U5 clinics)**
Timeframe	**2015-2020**
Evidence of success	**All service delivery points have FP method mix**

Total cost over timeframe	5-day meeting with MOH and stakeholders
Additional considerations	Use PPP (buses, other commodity deliver e.g. coca cola, to facilitate effective logistic system
Key stakeholders	MOHSW, PMORALG & DPs
Implementing agency(ies)	MOHSW, PMORALG & DPs
Indicator(s) (Data Source):	1. Policy guidelines are in place, 2. No. of copies of guideline printed, 3. No. of stakeholders received dissemination
Future PPFP Program 2:	
Increse FP service utilization	
Activity 1:	Capacity building of HRH to provide PPFP (through pre/in-service training)
Timeframe	2015-2020
Evidence of success	Integrated in the national postpartum care training curriculum for pre-/in-service
Total cost over timeframe	XXX for TOT/sussportive supervisors and providers training
Additional considerations	To ensure national trainers and tutors in schools are trained
Key stakeholders	MOHSW, PMORALG&DPs
Implementing agency(ies)	MOHSW, PMORALG and DPs
Activity 2:	Promote service integration with other programs to increase coverage and improve quality e.g. U5 growth monitoring, immunization, HIV treatment testing&counselling and treatment
Timeframe	2015-2020
Evidence of success	PPFP included in there service checklist manuals
Total cost over timeframe	XXX no. of meeting and review of materials
Additional considerations	High level stakeholders meeting is needed as advocacy
Key stakeholders	MOHSW, PMORALG and DPs
Implementing agency(ies)	MOHSW&DPs
Activity 3:	Linkage with community for continuum of care of PPFP
Timeframe	XXX no. of sessions to engage CHW/leaders
Evidence of success	No. of CHW complementing PPFP, No. clients referred for PPFP
Total cost over timeframe	XXX CHW trained on PPC monitoring and referral
Additional considerations	Ensure active involvement of community via leaders to refer postpartum women to PPFP
Key stakeholders	MOHSW, PMORALG&DPs
Implementing agency(ies)	MOHSW, PMORALG&DPs
Indicator(s) (Data Source):	1. No. of postpartum women enrolled for PPFP within 48-hours of delivery 2. No. of postpartum women enrolled in PPFP after 42 days of delivery
Future PPFP Program 3:	
Demand Creation for PPFP	
Activity 1:	Stengthen community engagement and male involvement for PPFP as integral part of FP

Timeframe	**2015-2020**
Evidence of success	**Running programs of community mobilization via media prints, radio&TV, electronic solutions e.g. mobile phone apps**
Total cost over timeframe	**XXX no. printed copies, XXX no. of TV programs, XX no. running mobile phone solutions**
Additional considerations	**Will need to conduct awareness around this program (IEC materials, demand creation on radio, etc.)**
Key stakeholders	**MOHSW, PMORALG&DPs**
Implementing agency(ies)	**MOHSW, PMORALG&DPs**
Activity 2:	**Monitoring and evaluation is in place**
Timeframe	**2015-2020**
Evidence of success	**Indicators for PPFP incorporated within MTUHA**
Total cost over timeframe	**XXX no. to incorporate indicators**
Additional considerations	**Involve the build up of this intervention MTUHA people**
Key stakeholders	**MOHSW, PMORALG&DPs**
Implementing agency(ies)	**MOHSW, PMORALG&DPs**
Activity 3:	
Timeframe	
Evidence of success	
Total cost over timeframe	
Additional considerations	
Key stakeholders	
Implementing agency(ies)	
Indicator(s) (Data Source):	**1. Different IEC materials in place, 2. No. of sessions conducted e.g. TV/radio programs, 3. Change of community practice and behaviour, 4. No. of mobile apps running**

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

PPFP Country Programming Strategies Worksheet

Country:	Tanzania	Country Coordinator:	Maurice Hiza

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:	**Postpartum Care (PPC) Program**			
1	Is input about the program being sought from a range of stakeholders?	Yes		These stakeholders are coordinated by RCHS
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		Once stakeholders have collaborated in developing the deliverables, MOHSW will be the key implimenting agency and these deliverables will remain as MOHSW documents for use at all levels.
4	Does the program address a persistent health or service delivery problem?	Yes		Dissemination and use of guidelines, lack of trained providers
5	Is the program based on sound evidence and preferable to alternative approaches?	Somewhat		Training providers using standardized methods has proven to improve quality of care, although is the traditional training methosd the best approach?
6	Given its financial and human resource requirements, is the program feasible in the local settings where it is to be implemented?	Yes		Funds need to be secured however.
7	Is the program consistent with existing national health policies, plans and priorities?	Yes		This activity is within national strategies and plans (One Plan).
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		Stakeholders agreed and collaborated on One Plan
9	Does the program identify and take into consideration community, cultural and gender factors that might constrain or support its implementation?	Yes		Cultural norms and practices will be a major obstacle.
10	Have the norms, values and operational culture of the implementing agency(ies) been taken into account in the program's design?	Somewhat		
11	Have the opportunities and constraints of the political, policy, health-sector and other institutional factors been considered in designing the program?	Yes		

	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?	Yes		
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?		No	Reliance on donor funds. However the program calls for larger initial investment (developing training materials, training providers) and ongoing supervision is part of routine MOHSW activities. Providers will need to be trained again at a later date.
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?	Somewhat		Shortage of trainable providers
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?	Yes		HMIS will capture necessary indicators
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?		No	
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		During stakeholder meetings
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

Scale-up Consideration		Yes	No	More Information/Action Needed
Future PPFP Program 2:	**Ensuring postpartum women have access to a full range of quaity FP methods**			
1	Is input about the program being sought from a range of stakeholders?	Yes		Through FP technical working group
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		Weak service integration is a major obstacle to reaching FP clients.
5	Is the program based on sound evidence and preferable to alternative approaches?	Somewhat		PPFP is still somehwat new in Tanzania. We can learn from other countries, and our experience with integration that this is an effective approach for reaching more FP clients, especially PP clients.
6	Given its financial and human resource requirements, is the program feasible in the local settings where it is to be implemented?	Yes		Some districts will be more feasible than others
7	Is the program consistent with existing national health policies, plans and priorities?	Yes		One Plan
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		
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?	Somewhat		
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		

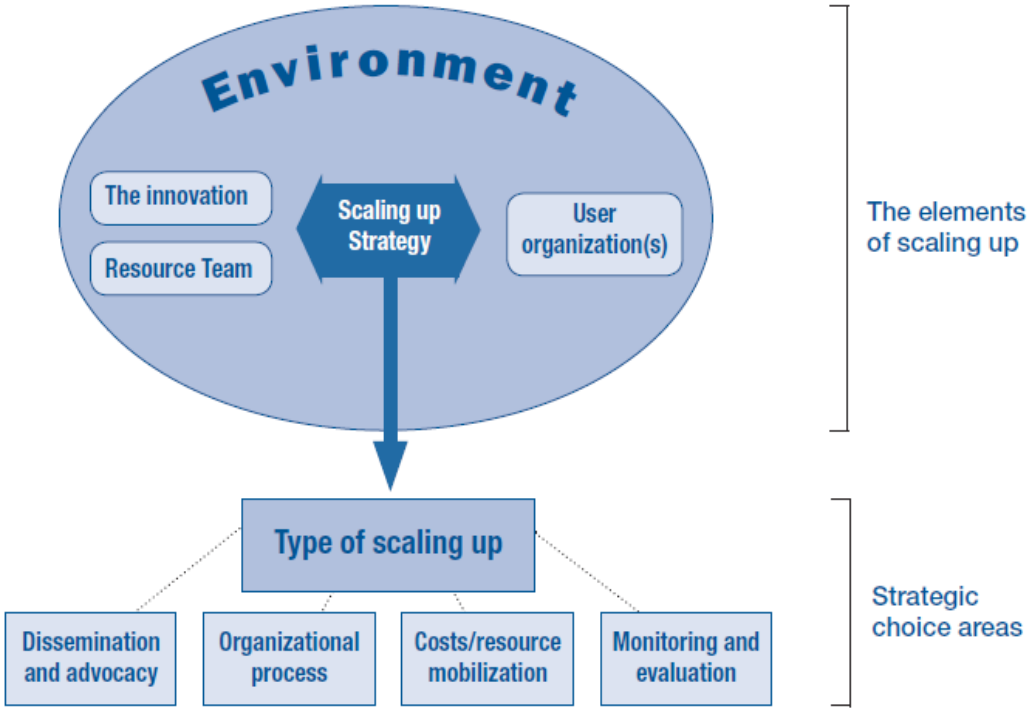
	Scale-up Consideration	Yes	No	More Information/Action Needed
15	Does the program require human and financial resources that can reasonably be expected to be available during scale-up?	Yes		
16	Will the financing of the program be sustainable?	Yes		
17	Does the health system currently have the capacity to implement the program? If not, are there plans to test ways to increase health-systems capacity?	Somewhat		Lack of skilled providers, space and infrastructure at facilities is innadequate for integration, commodity security still an issue
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?	Somewhat		Integration is not properly tracked in HMIS
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		PPFP needs to be included in preservice training curriculum, and task shifting should be emphasized for increaing providers that can offer FP methods, CHWs to provide injectables
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 3:	**Demand Creation for PPFP**			
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?			

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

	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?			
22	Is there a plan to share findings and insights from the program during implementation?			
23	Is there a shared understanding among key stakeholders about the importance of having adequate evidence related to the feasibility and outcomes of the program prior to scaling up?			

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



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Maternal and Child Survival Program

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

PPFP Country Programming Strategies Worksheet

Country:	Tanzania	Country Coordinator:	

VIII. PPFP Action Plan

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

	Task	Primary person responsible	Secondary person responsible	Deadline	What problems do you anticipate? What will you do when you encounter these (or other) problems?
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

	Task	Primary person responsible	Secondary person responsible	Deadline	What problems do you anticipate? What will you do when you encounter these (or other) problems?
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					