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.

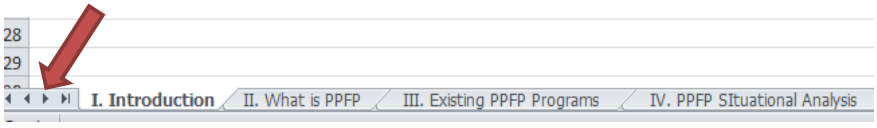
(4) For each of the future PPFP programs, complete a detailed PPFP Implementation Plan and consider how each program can best be scaled up to reach national and global family planning goals.

(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]

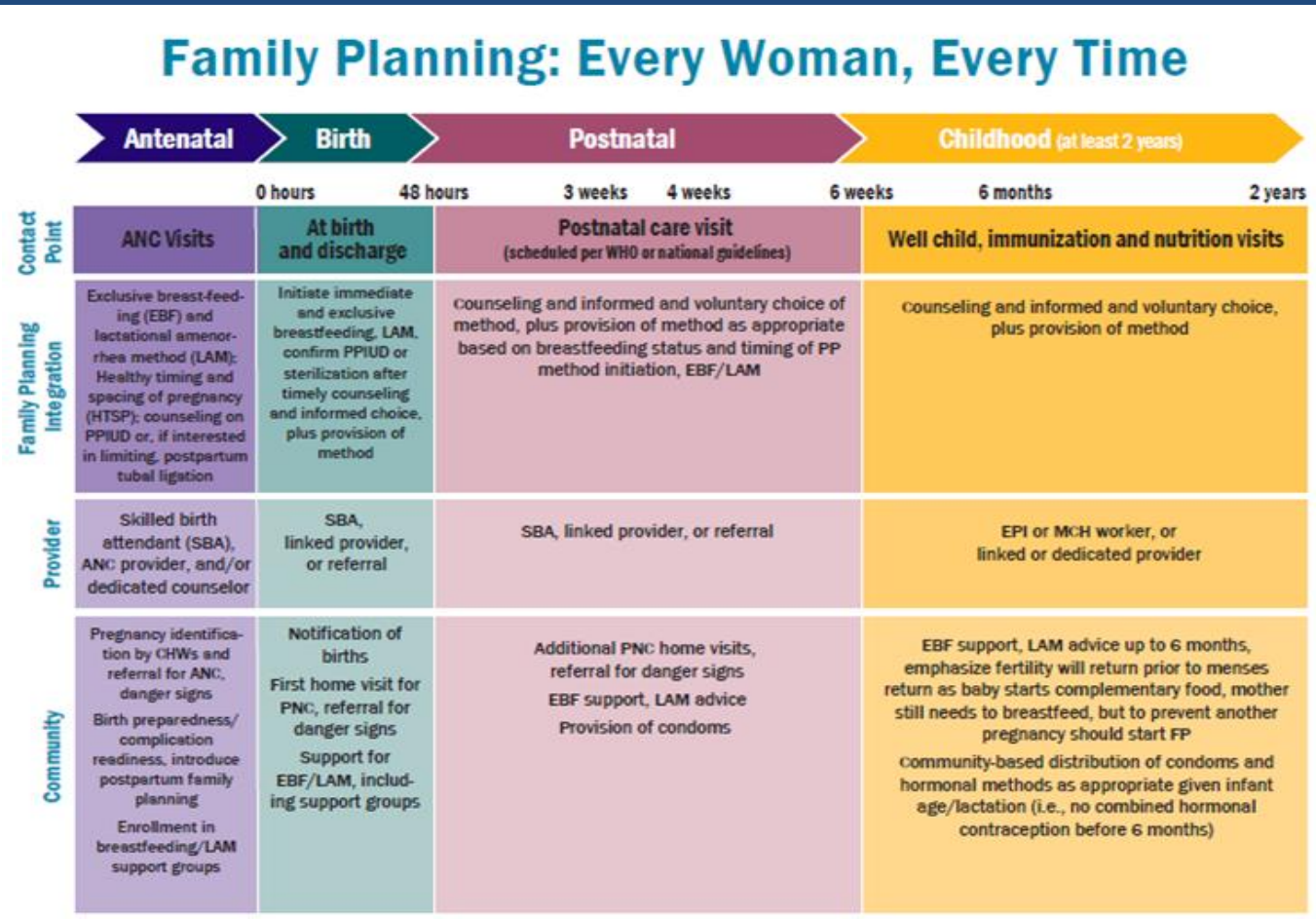
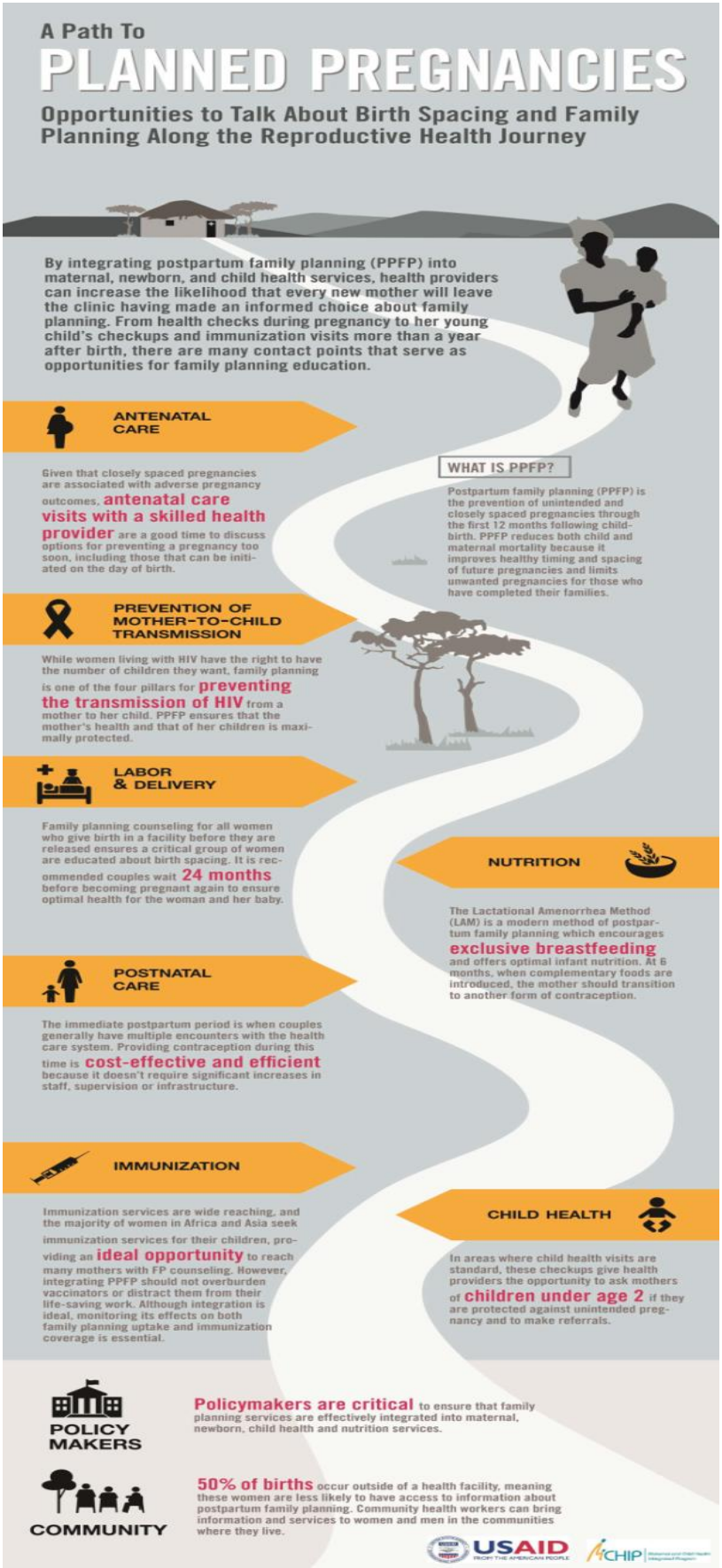


Figure 2. PPFP Integration Opportunities [MCHIP 2013]



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Country:	Uganda	Country Coordinator:	Lucy Asaba

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:	**PPFP CAPACITY BUILDING PROGRAM**
Activity 1:	**Strengthening the Policy environment to support PPFP**
Timeframe	**2010 - 2015**
Evidence of success	**SRHR Policy guidelines, Adolescent Health Policy and Strategy, Adaptation of the Medical Eligibility Criteria (3rd and 4th editions), Policy Addendum for Community-based FP, Strategy for integration of SRH into HIV, Costed implementation Plan, Training curriculum (PPIUD, PPFP) and guidelines, PPIUD job aid, Job aid for providing FP to an HIV positive client.**
Total cost over timeframe	**TBD**
Has this activity been scaled? Why or why not?	**Yes, but with limited dissemination**
Key stakeholders	**MOH, WHO, District Local Governments, World Bank, USAID, UKAID, UNFPA, AOGU, Parliament of Uganda, CSOs, IPs, Religious Medical Burueas, Religious leaders and institutions.**
Implementing agency(ies)	**MOH, JHPIEGO, PACE, MSH, MSI/U, WHO, RHU, ENGENDERHEALTH, MAKERERE UNIVERSITY COLLEGE OF HEALTH SCIENCES, AOGU.**
Activity 2:	**Training of providers working in Maternity, ANC, PNC, FP, YCC, Pre-service training institutions on PPFP.**
Timeframe	**5 years (2010 - 2015)**
Evidence of success	**Service uptake, service data, skills of service providers on PPFP, Reviewed curriculum to cater for PPFP, existence of the relevant job aid (PPIUD, PPFP).**
Total cost over timeframe	**TBD**
Has this activity been scaled? Why or why not?	**Yes, limited to areas with project support.**
Key stakeholders	**MOH, WHO, District Local Governments, World Bank, USAID, UKAID, UNFPA, AOGU.**
Implementing agency(ies)	**MOH, JHPIEGO, PACE, MSH, MSI/U, WHO, RHU, ENGENDERHEALTH, MAKERERE UNIVERSITY COLLEGE OF HEALTH SCIENCES, AOGU.**
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):	(i) Proportion of District Local Governments with policies and guidelines updated on PPFP (Data source: Supervision reports) (ii) Proportion of facilities with relevant job aids for PPFP (Data source: Supervision reports) (iii) # of Service providers trained in public and private sectors (Data source: Training inventory) (iv) # of clients served (counselled, acceptors by method) (Data source: HMIS tools and Facility registers, Activity reports)
Existing PPFP Program 2:	Demand Generation for PPFP
Activity 1:	PPFP CAPACITY BUILDING PROGRAM FOR COMMUNITY BASED PROVIDERS
Timeframe	5 years (2010 - 2015)
Evidence of success	Utilization data, referrals from the communities.
Total cost over timeframe	TBD
Has this activity been scaled? Why or why not?	Yes, limited to community-based DMPA, except Sayana press and Community Quality Improvement which are are pilots.
Key stakeholders	MOH, District Local Governments, USAID, UKAID, WHO, UNFPA.
Implementing agency(ies)	FHI360, MSH, PATH, MSI/U.
Activity 2:	Behavioural Change Communication intervention for PPFP
Timeframe	Jan - Dec 2014
Evidence of success	Utilization data: Total FP clients 3,717 were mobilized; of which 1,504 chose IUCD; 1,088 chose Implants; 316 chose injectable contraceptives; 119 chose Oral Contraceptives; 690 did not chose any modern method even after counseling.
Total cost over timeframe	TBD
Has this activity been scaled? Why or why not?	Not yet. Was a 1 year pilot.
Key stakeholders	MOH, District Local Governments.
Implementing agency(ies)	PACE
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):	**(i) # of clients served (referrals by CHWs, referrals by satisfied clients) (Data source: VHT registers and referral notes, Documentation journals, Activity reports, Facility Exit interview reports) (ii) Percentage of the community reached with PPFP message (Data source: survey results).**
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:	Uganda	Country Coordinator:	

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)	34,856,813 people (34.9 Million, UGA 2014, National Population and Housing Census)	Population that will benefit from families reaching desired size
2	Annual population growth, %	Population Reference Bureau "Rate of Natural Increase" (see Tab IX)	3.03% (UGA 2014, National Population and Housing Census)	Pace of population change that could be slowed with PPFP
3	Crude birth rate	Population Reference Bureau (see Tab IX)	42.1 live births per 1000 population (Uganda Demographic Health Survey-UDHS 2011)	Numbers of births occurring
4	Number of women of reproductive age (WRA)	Population Reference Bureau (see Tab IX)	7.3 Million (Census 2014)	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)	1.5 Million (Census 2014)	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)	6.2 (Uganda Demographic Health Survey 2011)	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)	4.7 (UGA 2014, National Population and Housing Census)	Compare with #6 on total fertility rate

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
8	Adolescent fertility rate	Population Reference Bureau (see Tab IX)	134 per 1,000 women (UDHS 2011)	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)	8.9 months; 16.4 months; 40.5 months; 17.9 months (UDHS 2011)	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)	1.7%; 6.6%; 8.3%; 10% (UDHS 2011)	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)	34% (UDHS 2011)	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)	21% (spacing); 14% (limiting) - (UDHS 2011)	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	?86% (UDHS 2011)	Population of women who *currently* need PPFP to reach desired family size and reduce maternal and child health risks

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
14	Contraceptive prevalence rate	Demographic and Health Survey (see Tab IX)	26% (UDHS 2011)	Population of women who are currently using family planning
15	Your country's CPR target	Government website or other publicly available reference	50% (National Family Planning Costed Implementation Plan, 2015 - 2020)	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)	19.7%; 3.2%; 4%; 3% (UDHS 2011)	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)	94.9% (UDHS 2011)	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)	Breastfeeding - about half of all children born are breastfed for about 19 months. More than six in ten children (63%) younger than 6 months are exclusively breastfed. (UDHS 2011)	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)	57.4% (UDHS 2011). The % of births taking place in a health facility is 57 % (2011 UDHS). 44 % are delivered in a public-sector health facility and 13% in a private sector facility. Delivery in a health facility is common among young mothers less than age 20 (66%) and mothers of first-order births (73%).	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)	41.6% (UDHS 2011)	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.

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
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	33% (UDHS 2011)	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	3.5%, (UDHS 2011). One-third of women receive postnatal care in the first two days after delivery. ☐ only 2 % received a postnatal checkup within one hour, while 13% received a postnatal checkup within six days.	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)	52% of children ages 12-23 months are fully vaccinated: 94% BCG vaccine, 72 % DPT 1-3 vaccinations, 63% polio 1-3, and 76% measles. Dropout rates 23 % for DPT and 33% for polio.	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	56 % of women and 55%of men age 15-49 have experienced physical violence at least once since age 15. 27% women and 22% men have experienced physical violence. 28% of women and 9% of men age 15-49 have experienced sexual violence at least once in their lifetime. Overall, 6 in 10 ever-married women and 4 in 10 men age 15-49 have experienced emotional, physical, or sexual violence from a spouse. 37 % married women and 26 % men who have ever experienced spousal violence (physical or sexual), reported experiencing physical injuries.	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]	54 abortions per 1,000 WRA (Guttmacher Institute study, 2003) = 376,920 abortions per year	Population that is at high maternal mortality risk and is likely to need postabortion care, including FP services
GOVERNANCE DATA				

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
26	**FP2020 Commitment** Country-level, public financial commitment to invest in FP	http://www.familyplanning2020.org/reaching-the-goal/commitments	Reduce unmet need for family planning to 10 % and increase the modern contraceptive prevalence rate (mCPR) amongst married and women in union to 50% by 2020. (1) Develop and implement an integrated family planning campaign. (Family planning materials developed under this campaign will carry the Ministry of Health, Government of Uganda land collaborating partners' logos.) 2. Accelerate the passing of the National Population Council Bill into law, immediately making the inter-ministerial structure functional and appropriating the necessary budget support, through a supplementary request, for 2012/13. 3. To improve RH commodity distribution and effective service delivery, review post shipment testing policy to reduce delays in release of vital Reproductive Health supplies, including family planning supplies, from National Drug Authority. 4. Meet the financial requirements to reach the above targets through: Increasing yearly government allocation for FP supplies from Shs 7.8b (US$3.3m) to Shs12b (US $5m) for the next 5 years; Ensuring strong accountability and coordination for all RH supplies and contraceptives procurement and distribution by Ministry of Health and National Medical Store, Uganda 5. Strengthen the technical and institutional functionality of Uganda Health Marketing Group and National Medical Store in a dual private and public sector RH supplies distribution system. 6. Scale up partnerships with Civil Society Organizations and private sector for FP outreach and community based services, including social marketing, social franchising and task sharing linked to a comprehensive training programme. 7. Partner with appropriate private sector bodies and institutions for the integration of MH/FP/RH and HIV&AIDS information and services for their employees and families - Roll out Youth Friendly Services in all Govt HC4s and District Hospitals 8. Ensure timely completion of the Annual Household Panel Surveys by Uganda Bureau of Statistics to ascertain progress on heath, including family planning, service delivery. Also, carry out a robust evaluation of all family planning investments in Uganda. 9. Conduct quarterly and bi- annual RH/FP. 10. Strengthen institutional capacity of the public health facilities and community based distributors to provide FP to increase choice and QoC at all levels (through staff recruitment, training, motivation and equipping).	
27	**Statement for Collective Action for PPFP Country Endorsement** Country-level, public support/champions for PPFP	http://www.mchip.net/actionppfp/	Government is committed to implement the PPFP Action Plan and will ensure that the necessary leadership for coordination and implementation is mobilization. The necessary resources (financial and human) are mobilized.	
28	**National FP Strategy** Where PPFP should be included or enhanced to affect national policy	Government website or other publicly available citation	The strategy is integrated with the National Sexual and Reproductive Health Strategy	
29	**FP Costed Implementation Plan** Where PPFP programs with budgets should be included or enhanced to affect national policy	Government website or other publicly available citation	Reduce unmet need for family planning to 10 % and increase the modern contraceptive prevalence rate (mCPR) amongst married and women in union to 50% by 2020. (FP Costed plan 2014). The total costs of the plan from 2015–2020 are $235 million USD (622 billion UGX). Overall, $115 million USD or 49 percent of the overall costs are in commodities, including contraceptives and consumables. Another 12 percent are in demand creation; 20 percent in service delivery; four percent in programming for contraceptive security; one percent in policy and enabling environment; less than one percent in financing; and 14 percent in stewardship, management, and accountability.	
30	Provide PPFP Implication for: "Provider cadres that are authorized to deliver PPFP services"	http://www.optimizemnh.org/intervention.php	Nurses, Midwives, Clinical Officers, Medical Officers for service providers. VHTs to mobilize the clients and provide basic methods of FP.	

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Country:	Uganda	Country Coordinator:	MOH supported by EngenderHealth

V. Health Systems "SWOT" Analysis

The structure of a country's health system greatly affects whether PPFP programs succeed, particularly as implementation moves to scale. Use the table below to conduct a Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis of each of the existing PPFP programs in sheet III. Existing PPFP Programs. List the internal strengths and weaknesses and the external opportunities and threats of each program from each health system dimension. For guiding questions, consult Section 2.2 in Chapter 2 of *Programming Strategies for Postpartum Family Planning* .

Existing PPFP Program 1:	

	Health System Dimension	**Strenths**	**Weaknesses**	**Opportunities**	**Threats**
I	Health Services				
	a. Public sector	Existence of VHTs for mobilizing the communities.	Sustainability issues regarding the VHT structure. Different RH capacity building programs for VHTs are implementing different things.	Many stakeholders and projects ongoing	VHT motivation and retention, inadequate. Limited coverage. Mainly implemented by IPs instead of Government.
		Training of service providers on PPIUD has commenced in a few districts.	(1) % of public facilities ready to offer PPFP is low (i.e. skilled staff, relevant equipment, suitable working environment with space and ensuring privacy, infection prevention facilities)	New Guidance on PPFP is now available for adaptation. Anatomical Models for CBT are globally available.	Human Resource for Health and Financial resources are inadequate.
		Policy on FP exists.	Policy does not address the current PPFP updates in the Medical Eligibility Criteria (MEC) 5th Edition.	Uganda has committed to the Global FP 2020. Some country programs are using the Total Market Approach to increase access to FP services.	Inadequate financing to support dissemination of policies and guidelines. Guidelines development is done by various IPs based on ongoing projects. Inadequate planning for regular updates on Policy, Guidelines and Standards.
	b. Faith-based/non-governmental organization (NGO)	Existence of the Public Private Partnership Policy. PPFP curriculum available for use. Faith-based organizations refer clients to where a full range of FP services exist and encourage LAM and Fertility awareness. There are available tools to practice fertility awareness.	Knowledge on Fertility awareness methods is still limited. Access to Guidelines and standards is poor.	Political will for FP envisaged in FP 2020. Religioius leaders are slowly embracing responsible parenthood. Packaging of the messages as Healthy timing and spacing of pregancy is acceptable to religious leaders. .	Dissemination of Policies, Guidelines and standards, is very low in the private sector.
		Skilled Human resource in PPFP exists in some places.	Insufficient supervision of Faith-based/ NGO providers.	Integration of PPFP into existing RMNCAH services	Dependency on donor priorities. Lack of suitable medical equipments for PPIUD. Limited Human resources for health especially Midwives in private sector. Limited financial resources to adequately implement PPFP.

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
1	b. Faith-based/non-governmental organization (NGO)	Have a big network of service providers and facilities.	(i) Some FBO do not promote modern methods of FP. (ii) Many potential clients are lost.	The FBO that do not promote modern methods of FP can be mobilized to promote LAM, refer other clients for other methods.	(a) Provider bias against LARCs. (b) Deliveries conducted at home. (c) Poor access to services to remove LARCs.
	c. Private sector	Training Guidelines have been adapted by implementing partners to cover PPFP. A pool of service providers already trained on interval FP exists. A pool of trainers for both interval and PPFP exists. Existence of Inter-Personal Communication (IPC) agents to mobilize communities exists. Clients that are willing to pay for services exist.	Some facilities do not prioritize Family Planning.	The Total Market Approach initiative provides an opportunity to access all clients for RMNCAH.	High attrition rate.
		Integration of Family Planning and HIV services exists in some clinics.	Technical skills to integrate PPFP into HIV and vice versa, is still limited. Follow-up of clients is a challenge.	Supportive Government policies exist.	Adherence to standards is a challenge. Weak internal referral mechanisms.
		Have a data management tool for PPFP.	Integration of FP data from the private facilities, into the national Government HMIS still weak.	Global inititatives like the UN Life Saving commodities and the Commission on provision of information and accountability, provide an opportunity to review the national data management tools. All stakeholders have an opportunity to participate in the review of the national HMIS.	Creation of parallel project-based data management systems.
2	Health management information system (HMIS)	Existence of HMIS (in public), that is also decentralized to the operational levels.	HMIS routine data is not disaggregated to cater for PPFP data elements. Computerization of data management has not yet infiltrated to the service delivery points.	Technical working group available to push for inclusion of PPFP indicators in HMIS. Existence of DHIS2 that all Implementing Partners can use to capture data and improve private sector data management. Global inititatives like the UN Life Saving commodities and the Commission on provision of information and accountability, provide an opportunity to review the national data management tools. All stakeholders have an opportunity to participate in the review of the national HMIS.	Creation of data management systems on individual program/ project basis, thereby creating duplication and provider burn-out. Coverage for internet connectivity still low.
3	Health workforce	Staffing in the Public and private sectors: At least a midwife from the level of HC III upwards exists and the infrastructure is conducive for provision of PPFP services.	Numbers of service providers is still inadequate both in public and private sectors. Pre-service and In-service training on PPFP is not prioritized.	Existing opportunities include Guidelines on Task-shifting.	Policy and Regulation on task-shifting have not yet been harmonized.

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
4	Medicines and technology	Some programs (HIV, Malaria) are now using web-based (WAO, mtrac, sms using mobile phones) to order supplies from the National Medical Stores and monitor stock status at the operational level. The country has a good method-mix by level of care. The FP commodities are part of the National Essential Medicines List. Two distribution channels cater for the public and the private sector needs of FP commodities.	Geographical coverage for the information technology, still limited. The newer Contraceptive technologies have not yet been introduced into the country. Skills of service providers to forecast FP commodity needs is weak.	(a) Experience to use WAO, mtrac and sms for FP exists. Trainable service providers are available. (b) Will use mobile assisted data collection methods under PMA2020, for improving household data capture on FP.	Network connectivity and electricity connectivity to the national grid is limited and inconsistent. High turn-over of trained staff.
5	Health financing	A National Costed Implementation Plan (CIP) has been developed to guide FP implementation by all stakeholders. It will be used as a resource mobilization tool. Franchizing as a mechanism for delivery of quality services exists in the private sector.	District funds are insufficient to support FP program implementation.	The increasing Global momentum to implement PPFP, use Total Market Approach for scaling up FP; The UN Commssion on essential medicines. purpose to include private sector facilities through voucher schemes.	The package covered under Health insurance does not include Family Planning.
6	Leadership and governance	Being strengthened at the national level. Uganda uses the Family Planning - Working Group to improve coordination in public sector. The private sector is using the Uganda Family Planning Consortium to improve coordination of FP Implementing partners.	Prioirity of the National Technical working groups has been on Commodity security. Coverage of the District Local Governements that actively advocate for FP scaling up, with good coverage for CPR, is low (<25%).	Political will for promoting FP services exists. Working under a Decentralized system is an opportunity for resource mobilization and for scaling up PPFP.	Project mode of implementation is difficult to coordinate.
7	Community and sociocultural				
	a. Community-based	Policy addendum on use of VHTs to provide information including LAM,pills,condoms, and Injectables FP.	Insufficient numbers of VHTs at village and country level.	VHTs exist but need to be further trained in FP to meet the demand.	Inadequate motivation for the VHTS; migratory tendencies between districts.
		Some districts have trained VHTs who are implementing community-based Depo injectable and Depo sub - cutaneous provision.	Weak distribution system for FP commodities.	Existence of community outreach programs e.g family health,Child health days,safe motherhood week,special days. for synergy.	Outreaches are not mapped for all villages.Some VHTs do not feel comfortable offering FP in client homes-they would rather offer it at their own homes rather than that of clients.
			Inadequate supportive supervision from trained service providers.Weak referral feedback mechanism.		
	b. Mobile outreach	Some IPs (MSI/U, PACE, UHMG, RHU, Engender Health,UNFPA) have supported Government to conduct outreaches (private and at public facilities).	Districts not yet sufficiently supported to conduct FP outreaches (funding, instruments, skills for organizing and running the outreaches)	Integration of FP outreaches with the national commemoration days (Safe Motherhood day, National Population day, National women's day, National AIDS' day, etc)	Insufficient funds to sustain outreaches

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
7	b. Mobile outreach	MOH and partners have developed a national guideline for basic requirements for carrying out FP outreaches.	Guidelines not yet widely disseminated by MOH.	Corporate social responsibility.Growing private sector.	Inadequate response by service providers to myths and misconception and management of side effects.Negative peer pressure.
		Some religious institutions are supported to conduct Family Planning and maternal child days outreaches.	Puiblic facilities provide FP on a daily basis but without focused communiy mobilization to attract many clients.	FP Advocacy strategy for parliamentarians is in final stages of development	Community resistance to utilise FP services.Negative powerful media which is not regulated.
	c. Social marketing	Ongoing capacity building of private clinics through formation of franchised networks that use principles of social marketing to ensure quality of care.	Franchised networks are mostly located in the urban and sub-urban areas	Public Private Partnership Policy offers a good opportunity for engaging the private sector in improving quality and provision of FP services according to set national standards.	
		Availability of a range of commodities branded for commercial and subsidized service provision in the private sector.	Weak engagement of the commercial service providers (Private for Profit service providers) hence difficulties in monitoring functioning of their Family Planning service delivery.	Opportunity exists for the Government to use the Total Market Approach to ensure Multi-Stakeholder involvement in increasing access to PPFP by all socio-economic segments of the population.	FP is not a profitable service for the private for profit sector hence reluctance for some to provide it.
		Brand promotional interventions done by the private sector on FP services and commodities, are carried out and mechanism to evaluate impact are in place.	Social marketing by the private sector on PPFP has not yet been scaled up. Social marketing is weak in the public sector.	Public sector can tap on the expertise of the private sector in implementing Behavioural Change Communication activities.	
Existing PPFP Program 2:					
Health System Dimension		**Strenths**	**Weaknesses**	**Opportunities**	**Threats**
1	Health Services				
	a. Public sector	Clinics for mobilizing and counseling PPFP clients exist (e.g. Young Children's Clinics, ANC, Postnatal Clinic), especially in the public sector.Guidelines for delivery of PP and PNC are available.	Pre and in-service training is weak on Post Partum and Post Natal Care service provision. Continuum of care: Weak Postnatal care service provision. Weak follow-up of the counselled clients to ensure that they access PPFP.Guidelines do not capture edition 5 MEC not provided for and will need to be updated.Many previous guidelines not disseminated	Many training opportunities for RMN exist.Existence of new global initiatives e.g UN Life Saving Commodities,RMNCAH trust fund,FP2020. Facility deliveries.	(a) Provider bias (b) Deliveries conducted at home. (c) Poor access to services to remove LARCs.

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
1	a. Public sector	Integration of Family Planning and HIV services exists in some facilities.	Technical skills to integrate PPFP into HIV and vice versa, is still limited.	Updated PPFP strategy and 5th edition of MEC now in place.WHO guidelines on PNC,PPFP and integration.	Insufficient numbers of health workers.
	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
1	Health Services				
	a. Public sector				

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
1	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				

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

PPFP Country Programming Strategies Worksheet

Country:	Uganda	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:	
Policy,Tools,M&E and technologies,Capacity Building(skills,nos,equipment,commodities and logistics management,models,infrustructure)co-ordination and stewardship,demand generation and service delivery(mode/modals and innovations).	
Activity 1:	**Adaptation of the 5th Edition of MEC into the existing policies and guidelines to provide for PPFP**
Timeframe	**July-September 2015**
Evidence of success	**1.Existence of 10,000 copies of revised and approved guidelines .2.disseminated copies to stakeholders 3.**
Total cost over timeframe	**TBD**
Additional considerations	**MOH to lead the process;TA from WHO,IBP,FP2020,Jhpiego,AFP; key stake holders will be consulted(training institutions and professional bodies);dissemination workshops.**
Key stakeholders	**IPs,religious and cultural leaders,parliamentarians**
Implementing agency(ies)	**MOH, JHPIEGO, PACE, MSH, MSI/U, WHO, RHU, ENGENDERHEALTH, MAKERERE UNIVERSITY COLLEGE OF HEALTH SCIENCES, AOGU.**
Activity 2:	**Reinvigorating the RH/FP WG for better co-ordination and stewardship for PPFP at National and District level.**
Timeframe	**July 2015 onwards**
Evidence of success	**Actionable points executed from monthly co-ordination meetings at national and 112 districts.**
Total cost over timeframe	**TBD**
Additional considerations	**MOH to lead the process;Multi-stake holder involvement,functional secretariate**

Key stakeholders	FP NGOs and CSOs,Extended District Health Management Teams,religious medical bureaus,development partners,CSOs
Implementing agency(ies)	MOH and DHTs
Activity 3:	Pre- and In-service training for provision of Quality PPFP services
Timeframe	October 2015 - September 2016
Evidence of success	Competent Health workers providing PPFP services
Total cost over timeframe	TBD
Additional considerations	Cascaded beginning by TOT with country divided into 7 regions. Follow-up,Coaching and Mentorship and Technical Support Supervision,Should be integrated with EMTCT training,adolescents,(AFR 134/1000),ART Clinics,YCC,Nutrition(MIYCN),ART and ANC).Procurement of Mama-U,Ritas Arm,Vasectomy Kit training kits,Mama Natalie,Neonatalie,Prim Natalie,Post Partum Introducer for IUD,PPIUD insertion kits,Post Partum insertion kits.Pregna introducer,remodelling to take care of confidentially and privacy
Key stakeholders	IPs, Local Govt, Health training institutions
Implementing agency(ies)	MOH, JHPIEGO, PACE, MSH, MSI/U, WHO, RHU, ENGENDERHEALTH, MAKERERE UNIVERSITY COLLEGE OF HEALTH SCIENCES, AOGU.PATH,PATHFINDER,FHI360,JSI,URC,DHTs,NACME,Medical Access,NMS,JMS,Merck,Religious Medical Bureaus,TASO,Mild May,CDC
Indicator(s) (Data Source):	(i) Proportion of District Local Governments with policies and guidelines updated on PPFP (Data source: Supervision reports) (ii) Proportion of facilities with relevant job aids for PPFP (Data source: Supervision reports) (iii) # of Service providers trained in public and private sectors (Data source: Training inventory) (iv) # of clients served (counselled, acceptors by method) (Data source: HMIS tools and Facility registers, Activity reports) DHIS2,(v)Proportion of actionable points executed.(minutes)
Future PPFP Program 2:	
Activity 1:	Scale up community based promotion of PPFP and provision of Depo and Sayana Press
Timeframe	October 2015 - September 2016
Evidence of success	Competent VHTs providing PPFP services including method provision
Total cost over timeframe	TBD
Additional considerations	Limit Sayana Press to pilot areas 30 districts,phasic spread of Sayana Press;CQI interventions, close supervision by Public and Private sector, tools, supplies, IEC materials, Job aides, VHTkits, Quarterly review meetings
Key stakeholders	IPs,religious and cultural leaders,parliamentarians,DLG
Implementing agency(ies)	MOH, JHPIEGO, PACE, MSH, MSI/U, WHO, RHU, ENGENDERHEALTH, MAKERERE UNIVERSITY COLLEGE OF HEALTH SCIENCES, AOGU.
Activity 2:	Strengthen Logistic Management for provision of PPFP at all levels in both Public and Private

Timeframe	October 2015 - September 2016
Evidence of success	Availability of right contraceptive mix,lack of stock outs,no expiry of commodities
Total cost over timeframe	TBD
Additional considerations	Availability of accurate utilisation data,involvement of both private and public facilities,Public sector distribution mechanism,alternative distribution channels.accountability for supplies,supervision,Medicines and Therapeutic Committees,Co-ordination meetings.innovations:mtrac etc
Key stakeholders	MOH,IPs,DHTs,UHMG,USAID,UNFPA,WHO,Religious Medical Bureaus,National Drug Authority,Private Practitioners
Implementing agency(ies)	MOH,UHMG,PACE,MSU,DHTs,NACME,Medical Access,NMS,JMS,Merck,Religious Medical Bureaus,MSH
Activity 3:	Create Demand for PPFP
Timeframe	October 2015 - September 2016
Evidence of success	Utilisation data disaggregated by method and period
Total cost over timeframe	TBD
Additional considerations	Mass Media,VHTs,IPC,male involvement,social marketting,social media(twitter,whatsapp),local,cultural and political leaders
Key stakeholders	MOH,DHTs,UHMG,USAID,UNFPA,PACE,WHO,Religious Medical Bureaus,RHU,MSU,Engender Health,MSH,UKAID,UNICEF,UNAIDS,MOGLSD
Implementing agency(ies)	MOH,DHTs,UHMG,PACE,Religious Medical Bureaus,RHU,MSU,Engender Health,MSH,CSOs,FHI360,PATH,World Bank,Mild May,TASO
Indicator(s) (Data Source):	No of clients counselled for PPFP in ANC and Maternity,uptake disaggregated for method
Future PPFP Program 3:	
Activity 1:	Strengthen PPFP service delivery in the public and private sectors.
Timeframe	June 2015 - September 2016
Evidence of success	Increased PPFP service utilization and consumption statistics, Scale up of existing service models.
Total cost over timeframe	

Additional considerations	Innovations to be used such as Sayana Press for community-based service provision, Integration with Adolescent-friendly services, HIV programs, and other Reproductive Maternal Neonatal Child Adolescent Health servives, Outreaches/ FP events, Family Health days. Will use already trained Village Health Teams (VHTs) to deliver selected PPFP services. Male involvement will be a key consideration. Community quality improvement initiatives. Entry point for PPFP services will commence during the ANC. Will employ Provider Behavioural Change Communication (PBCC) and Values Clarification training to address provider bias where applicable. Shall emphasize and document continuum of care through tracking clients referred for PPFP and feedback. Will adapt the WHO Quality of care tool, and harmonize existing PPFP checklists for quality of care. Ongoing technical supervision and mentoring.
Key stakeholders	MOH, USAID, Bill & Melinda Gates Foundation, WHO, UNFPA, UNICEF, District Local Governments, AOGU and Paediatric Association, Religious Medical Bureaus, MSI/U, PACE, RHU, Engenderhealth, UHMG, JHPIEGO, Pathfinder, FHI360.
Implementing agency(ies)	MOH, WHO, UNFPA, UNICEF, District Local Governments, AOGU and Paediatric Association, Religious Medical Bureaus, MSI/U, PACE, RHU, Engenderhealth, JHPIEGO, Pathfinder, FHI360.
Activity 2:	Research, Monitoring, Evaluation and Accountability of the PPFP Program in the public and private sectors.
Timeframe	June 2015 - September 2016
Evidence of success	A Monitoring and Evaluation framework including core PPFP indicators with supporting data management tools. Research areas identified.
Total cost over timeframe	
Additional considerations	Baseline data will be sourced from available statitistics (DHS, PMA2020, DHIS2, Existing PPFP project reports). Will employ technologies for data management (e.g. sms, mtrac, Special and scheduled surveys like DHS and PMA2020. Will engage additional support to ensure quality (technical officers- numbers & skills, computerization). Will require review of existing data management tools to address PPFP, data verification and validation, technical supervision and mentoring. Accountability will cater for Rights-based approach, gender-responsiveness, Quality of care. Will use the MOH Client charter to follow-up client satisfaction after translation into local languages .
Key stakeholders	MOH, District Health Teams, Uganda National Health Research Organization, JHPIEGO, PACE, MSH, MSI/U, WHO, RHU, ENGENDERHEALTH, FHI360, MAKERERE UNIVERSITY COLLEGE OF HEALTH SCIENCES, AOGU, Religious Medical Bureaus, religious & cultural leaders, Parliamentarians, Pathfinder, Community, Midwifery Training School, Uganda National Health Consumer Organization.
Implementing agency(ies)	MOH, JHPIEGO, PACE, MSH, MSI/U, WHO, RHU, ENGENDERHEALTH, MAKERERE UNIVERSITY COLLEGE OF HEALTH SCIENCES, AOGU.
Activity 3:	Mobilise resources for PPFP services
Timeframe	May 2015 - onwards
Evidence of success	Financial records, utilisation data, functional and financial accountability
Total cost over timeframe	TBD

Additional considerations	**(i) Use voucher system in public and private facilities for extending services to the vulverable groups (rural and urban poor, Most At Risk Populations, Hard-to-reach, adolescents, migratory populations, etc). This initiative will observe: Capacity building for service providers, Provision of quality PPFP services, Existance of a Governing Board for the scheme, A Voucher management agency, Facility data management system, Accreditation of the facilities to implement the scheme (ii) National Health Insurance scheme (for the future) (iii) Use the FP Costed Implementation Plan (CIP) to mobilize resources.**
Key stakeholders	**MOH, District Local Governments, World Bank, WHO, UNFPA, USAID, UKAID, IPPF, IBP,Bill and Melinda Gates, Religious Medical Bureaus.**
Implementing agency(ies)	**MOF, MOH, Selected Health facilities, MSIU**
Indicator(s) (Data Source):	**(i) National FP work-plan with a budget-line for PPFP (ii) Proportion of District Local Governments with Budget lines for FP including PPFP (iii) Proportion of facilities with relevant job aids and appropriate IEC materials for PPFP (Data source: Supervision reports) (iv) # of clients served (counselled, acceptors by method and timing) (Data source: HMIS tools and Facility registers, Activity reports, DHIS2) (v) Proportion of actionable points executed (supervision reports) (vi) Proportion of facilities in the project area using data management tools that are updated for PPFP.**

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

PPFP Country Programming Strategies Worksheet

Country:	Uganda	Country Coordinator:	

VII. Considerations for Scale-up

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

	Scale-up Consideration	Yes	No	More Information/Action Needed
Future PPFP Program 1:				
1	Is input about the program being sought from a range of stakeholders?	Yes		The plan has been shared with FP Working group (FP Stakeholders); MOH MCH Cluster group and implementing organizations
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)?			
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 stakeholder 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 culture of the implementing agency(ies) been taken into account in the program's design?			

	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?			
12	Have the activities for implementing the program been kept as simple as possible without jeopardizing outcomes?			
13	Is the program being implemented in the variety of sociocultural and geographic settings where it will be scaled up?			
14	Is the program being implemented in the type of service-delivery points and institutional settings in which it will be scaled up?			
15	Does the program require human and financial resources that can reasonably be expected to be available during scale-up?			
16	Will the financing of the program be sustainable?			
17	Does the health system currently have the capacity to implement the program? If not, are there plans to test ways to increase health-systems capacity?			
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?			
19	Is there provision for early and continuous engagement with donors and technical partners to build a broad base of financial support for scale-up?			
20	Are there plans to advocate for changes in policies, regulations and other health-systems components needed to institutionalize the program?			
21	Does the program include mechanisms to review progress and incorporate new learning into its implementation process?			
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

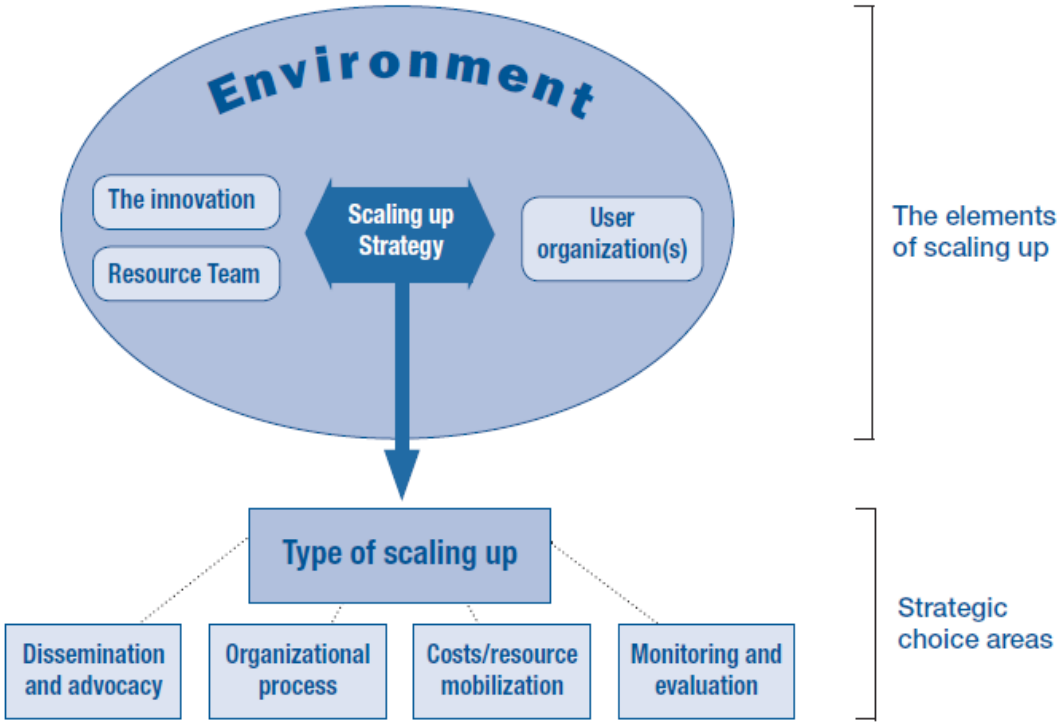
	Scale-up Consideration	Yes	No	More Information/Action Needed
	Future PPFP Program 2:			
1	Is input about the program being sought from a range of stakeholders?			
2	Are individuals from the implementing agency(ies) involved in the program's design and implementation?			
3	Does the program have mechanisms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

	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?			
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:		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	REVIEW NATIONAL RH/FP POLICY AND GUIDELINES: - Meetings of Core PPFP team to review MEC guidelines, MEC wheel and RH National Policy guidelines and RH/FP Training Curricula; FP Working group to revise the documents	MOH	WHO, EngenderHealth; AOUGU; JHPIEGO; PACE	20-Oct-15	
2	STRENGTHEN COORDINATION WITH PARTNERS: presentation of PPFP Plan to FP Working group; - presentation of PPFP plan to MOH MCH Cluster	MOH, WHO, JHPIEGO; AOUGU, Makerere University, EngendeHealth, PSI, MSH		Sep-15	Multi-stakeholder involvement
3	INNOVATIVE SERVICE DELIVERY: -Capacity building PPFP Core team - Orientation meetings on Updated MEC guidelines (2015) to different stakeholders and fora; Orientation of service providers on PPFP and MEC; Field testing the revised guidelines	MOH, JHPIEGO, EngenderHealth, AOGU, PACE, MSH	FP Stakeholders	TBD	Getting the PPFP Agenda into Stakeholder plans; Funds for training
4	Training of service providers in the private facilities on PPFP; PPIUD training of service providers in the public facilities:	MOH, PACE; JHPIEGO; AOGU	JHPIEGO, EngenderHealth, AOGU, PACE, MSH & FP Stakeholders	TBD	

	Task	Primary person responsible	Secondary person responsible	Deadline	What problems do you anticipate? What will you do when you encounter these (or other) problems?
5	MONITORING, EVALUATION AND ACCOUNTABILITY; Edit guidelines based on field testing findings; Dissemination of guidelines; Documentation of processes, health outcomes, lessons and best practices; Data collection and use for decision making	MOH, JHPIEGO, EngenderHealth, AOGU, PACE, MSH	All FP Stakeholder involved in PPFP	on going	Reporting on PPFP in HMIS
6					
7					
8					
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15					

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