WHO FP Accelerator Plus

BNA Tool Annexes: Module A - PPFP

Annex A1: PPFP background & recommendations

Background on post-pregnancy FP (PPFP)

Provision of contraception to postpartum and post-abortion women is recommended by WHO[1] and promoted by USAID and its partners as a high-impact practice for increasing contraceptive coverage.[2] These two groups of women both have critical needs for contraceptive protection:

Postpartum women often have an unmet need for birth spacing. Healthy birth spacing can reduce the risks associated with short inter-pregnancy intervals, both to the mother, newborn and her other children. Unintended and closely spaced births are associated with increased maternal, newborn, and child morbidity and mortality,[3,4] and WHO recommends that women wait at least two years before planning to become pregnant again.[5] WHO also recommends that contraceptive counselling should be offered across a continuum of maternal and newborn health care during pregnancy and postpartum (see Figure 1).[1]

Post-abortion women[1] (including women attending for abortion care or post-abortion care) have usually experienced an unintended pregnancy. Post-abortion women usually have an unmet need for family planning are often keen to take up modern contraceptive methods to avoid either the costs, inconvenience or any risks associated with repeat abortion if access to safe abortion care is legally restricted.

Figure 1: Continuum of points of contact for PPFP (WHO, 2013)

CONTINUUM OF POINTS OF CONTACT FOR PPFP → → → →				
STAGE	Pregnancy	Labour and delivery, Pre-discharge (0–48 hours)	Postnatal, including prevention of mother-to-child transmission of HIV (PMTCT) (48 hours–6 weeks)	Infant care (4–6 weeks through 12 months)
SERVICE DELIVERY	Facility-based antenatal care (ANC) Community-based pregnancy screening	Facility-based or home-based with skilled birth attendant	Facility or household visits: • If birth at home, within 24 hours of birth • If birth in facility, prior to discharge • Day 3 (48-72 hours) • Between days 7-14 after birth • 6 weeks	Facility, home visit, or community-based: • Immunizations (diphtheria-pertussis-tetanus [DPT] or Pentavalent 1, 2, 3; measles, rotavirus; boosters; etc.) • Well child visits • Nutrition/growth monitoring • Event days (e.g. vitamin A) • Illness visits (e.g. Integrated Community Case Management/Integrated Management of Childhood Illnesses [iCCM/IMCI]) • PMTCT/antiretroviral care and treatment

Despite efforts over many decades to promote PPFP, many women's contraceptive needs in the postpartum and post-abortion period go unmet. Yet with marked increases in use of maternal and newborn services over past years, including ANC, assisted delivery and PNC, there are multiple opportunities to promote and offer contraception to pregnant and postpartum women. Women accessing abortion/post-abortion care within facilities can also be offered most methods of contraception to start immediately following an abortion.

[1] Women receiving abortion care or post-abortion care for induced abortions, not spontaneous abortion.

The reasons why use of post-pregnancy contraception remains low are multi-faceted and stem both from inadequate provision by the health system as well as low demand (especially in the postpartum period).

On the health systems side, a recent WHO systematic review identified a range of bottlenecks to PPFP provision documented in the published literature. These are detailed below. In brief, they include a range of health systems factors that are often found to inhibit effective health service delivery in resource-constrained settings, including human resources availability, capacity, motivation and attitudes; supplies/equipment; resourcing; fees; health management information systems (HMIS); political leadership, health sector coordination. Similarly, studies on post-abortion care find lack of trained staff, heavy provider workloads, method stockouts, and poor provider knowledge are frequent challenges. The increased use of medical abortion may also be inhibiting uptake of immediate post-abortion contraception, either due to increased self-use via pharmacies, or as women wait for abortion completion to occur (up to 2 weeks later).

On the demand side, various socio-cultural and gender norms interplay with physiological factors influencing desire to initiate contraception, among postpartum women. Postpartum amenorrhoea induced by breastfeeding offers a natural alternative to women who may be keen to avoid hormonal methods (due to fears of impacts on the newborn through breastmilk). The lactational amenorrhoea method (LAM) is highly effective at preventing pregnancy in the first six months postpartum if women are fully (or nearly fully) breastfeeding, but users need counselling on breastfeeding practices as well as support to transition to another contraceptive method before the six months ends. Reduced sexual activity (where postpartum abstinence is observed) also lowers demand but may leave women unprotected when sexual activity resumes. Fears of contraceptive side effects are common across many countries, and may be particularly influential among breastfeeding women, and many women who do initiate postpartum FP use discontinue it within short time-frames.[6] In post-abortion women, common barriers to contraception (fear of health impacts, fears of side effects, partner acceptance) may be elevated (vs the general population) given their non-use of contraception before pregnancy.

Given the importance of data for health monitoring and improvement, WHO and its partners also recommend the need for HMIS to routinely capture postpartum and post-abortion FP provision. Data on PPFP provision in health facilities has been inconsistent, but USAID, FP2030 and other international partners now recommend that all maternity facilities should monitor the percentage of women who receive a modern contraceptive method before discharge (including lactational amenorrhoea method (LAM) (essential) as well as the percentage of women who receive FP counselling before discharge (ideal), to be captured within routine health management information systems (HMIS).[7] Many abortion programmes also routinely monitor the percentage of women who take a contraceptive method before discharge.

WHO clinical recommendations on PPFP

The following key recommendations are made in WHO guidelines listed below:

- Postpartum women can immediately initiate progestogen-only pills and progestogen-only implants after delivery; can initiate progestogen-only injectables (DMPA, NET/EN) 6 weeks after delivery; IUD within 48 hours or from 4 weeks after delivery; and combined hormonal contraceptives (pills, patches, vaginal rings, combined injectables) 6 months after delivery.
- Postpartum women who choose to initiate progestogen-only methods within the first 6 months of delivery can do so immediately without the need to rule-out pregnancy.

- Postpartum women who choose to use the lactational amenorrhoea method (LAM) or who decide against contraception because they are breastfeeding should be supported to transition to another method within 6 months of delivery, since protection against pregnancy is only assured during the first 6 months if she is fully or nearly fully breastfeeding and amenorrhoeic.
- Post-abortion women can initiate all hormonal methods of contraception immediately, or within 7 days of abortion without the need to wait for menstruation. Women taking medical abortion drugs can start contraception after taking the first pill (mifepristone or misoprostol) of the medical abortion regimen, except for IUDs which can be inserted after the abortion has been determined to be successful.

WHO guidelines with PPFP Recommendations:

- *The Postpartum Family Planning Compendium (online tool)*
- *Family Planning – A Global Handbook for Providers 2022 Edition*
- *Programming Strategies for Postpartum Family Planning (2013)*
- *Clinical Practice Handbook for Quality Abortion Care (2023)*
- *Medical Eligibility Criteria for Contraceptive Use 5th Edition* (NOTE: This guideline has not been updated with the latest PPFP recommendations contained in the PPFP Compendium, namely that women can initiate POPs and POIs immediately after birth).
- *Selected Practice Recommendations for Contraceptive Use 3rd Edition*

Bottlenecks identified in WHO systematic review

The following factors, organised into the WHO health systems building blocks, were identified in a recent WHO systematic review on PPFP scale-up,

i) People

• Family involvement, accompaniment, and tradition
• Fear of judgment
• Lack of interest
• Knowledge regarding LAM and suitable contraceptive methods
• Loyalty toward the religious doctrines in religious based hospitals in post abortion contraceptive counselling instead of applying national family planning guidelines
• Male partner:
– Integration of men
– Partner sharing in decision making
• Myths and misinformation, Misconceptions about modern contraception
• Perceived quality of facility services
• Factors related to postnatal care
– Prioritization by women of scheduled postpartum visits
– Opportunities to encourage continuity of care, especially for PPFP
– A contraception-dedicated six-week postpartum
• Religious and traditional norms:
– Sexual abstinence for up to three to six months PP
– Social pressure to closely space pregnancies
– Traditional views on the consequences borne by closely-spaced children and their mothers
– Cultural and religious objections to family planning and lingering misconceptions

ii) Service delivery

• Access to facility services

• Factors related to counselling
– dedicated PPFP counseling materials
– privacy within the health facility
– time necessary to fully counsel women on all available and appropriate methods
– Time required for One to one counseling
• Limited availability of clinic days and scheduled visits dedicated to contraception
• Extent of ANC coverage

iii) Medical products

• Available equipment and supplies
• Availability of readily accessible methods and plans for stock-outs in health facilities.

iv) Financing

• Challenges with Engaging private insurance companies
• Financial risk intolerance
• LARC device cost/reimbursement
• Administrative infrastructure and financial flexibility
• Out-of-pocket payment of contraceptives
• Cost/Fund to buy or to purchase the instruments or LARC by health facilities

v) Health information systems

• Challenges in acquiring data use agreements between public health and medicaid
• Difficulty analyzing raw medicaid claims data
• Long duration for resolving technical billing issues
• Technical complexity of information technology system for claims processing
• Pre-existing strong collaborations across agencies with respect to data

vi) Leadership and governance

• Leadership stability
• Support from high-level leadership
• Clinical champions
• Co-location of health department and financial agency and/or strong pre-existing working relationship between agencies.
• Connecting with rural birthing facilities
• Translating what works across various contexts
• Effect of political sensitivity around contraception on team's ability to work on increasing LARC access
• Political commitment to post abortion and postpartum FP programs.
• Process change for coders and pharmacy staff members

vii) Health workforce

• Ability to work with other teams in the learning community and share resources
• Continued support and guidance from trainers in informal follow-up visits and phone calls
• Judgmental treatment from health providers
• Inability to perform the procedure or Lack of knowledge/skills about all contraceptive methods
• Lack of live clinical insertions
• Lack of supervision throughout practice insertion sessions
• Pre-existing personal connections of team members
• Shared culture and language facilitated the training, reduced miscommunication between teams, and built engagement and mutual support
• Spill over: hearing about process from others in the learning community
• Team members long and continuous involvement with immediate postpartum LARC initiative
• Turnover in team members
• Uncertainty about goal for immediate postpartum contraceptive use

Annex A2: BNA Planning tool

This is a suggested time-frame for implementing BNA activities (modules A-C). This assumes that the different module content can be assessed simultaneously. The editable version is contained in the BNA Excel sheet.

		Enter progress here:	Week no.							
TASK	ASSIGNED TO, e.g.:	PROGRESS	1	2	3	4	5	6	7	8
Preparation										
Assessment tool review	BNA consultant	0%								
Problem definition, assessment adaptation and optional preparatory field visit	BNA consultant	0%								
Ethics exemption (if required)	BNA consultant	0%								
PPFP Assessment										
National data review	BNA consultant	0%								
Guidance & policy alignment assessment	BNA consultant	0%								
Case studies	BNA consultant	0%								
Open-ended questionnaire	BNA consultant	0%								
Questionnaire analysis	BNA consultant	0%								
Workshop preparation	BNA consultant	0%								
PPFP Consensus workshop	BNA consultant	0%								
Task-sharing assessment										
National data review	BNA consultant	0%								
Guidance & policy alignment assessment	BNA consultant	0%								
Case studies	BNA consultant	0%								
Open-ended questionnaire	BNA consultant	0%								
Questionnaire analysis	BNA consultant	0%								
Workshop preparation	BNA consultant	0%								
TS Consensus workshop	BNA consultant	0%								
SBC assessment										
National data review	BNA consultant	0%								
Guidance & policy alignment assessment	BNA consultant	0%								
Case studies	BNA consultant	0%								
Open-ended questionnaire	BNA consultant	0%								
Questionnaire analysis	BNA consultant	0%								
Workshop preparation	BNA consultant	0%								
SBC Consensus workshop	BNA consultant	0%								

Annex A3: Data review for PPFP

				Responses *(Enter ND if no data available)*				
Background: Current FP status	**Module**	**Potential Data source**	**Suggested breakdown**	**All WRA**	**Rural WRA**	**Urban WRA**	**<20 WRA**	**>=20 WRA**
% of FP accessed in the public sector	All	DHS	Rural/urban, <20/>=20					
% of FP accessed in the non-profit private sector	All	DHS	Rural/urban, <20/>=20					
% of FP accessed in the for-profit private sector	All	DHS	Rural/urban, <20/>=20					
Modern contraceptive prevalence (% among women of reproductive age)	All	DHS or PMA	Rural/urban, <20/>=20					
% all women of reproductive age relying on Long Acting or Permanent methods of FP	All	DHS or PMA	Rural/urban, <20/>=20					
% all current contraceptive users relying on Long Acting or Permanent methods of FP	All	DHS or PMA	Rural/urban, <20/>=20					
% of women with unmet need for FP	All	DHS or PMA	Rural/urban, <20/>=20					
% of women with unmet need for FP for spacing births	All	DHS or PMA	Rural/urban, <20/>=20					
% of all WRA who are < 12 months postpartum and not using modern contraception	PPFP	DHS or MICS	Rural/urban, <20/>=20					
% of women who give birth in facility who are <12 mo postpartum and not using MC	PPFP	DHS or MICS	Rural/urban, <20/>=20					
% women < 2 years postpartum who discontinue contraception within 3 months of use *(may require analysis of DHS calendar data)*	PPFP	DHS	Rural/urban, <20/>=20					
% of women who receive ANC from a skilled provider	PPFP	DHS or HMIS or DHS	Rural/urban, <20/>=20					
% of women with recent birth who have a post natal check up within 6 weeks	PPFP	DHS	Rural/urban, <20/>=20					
Median duration of exclusive breastfeeding	PPFP	DHS	Rural/urban, <20/>=20					

				Responses *(Enter ND if no data available)*				
Background: Current FP status	**Module**	**Potential Data source**	**Suggested breakdown**	**All WRA**	**Rural WRA**	**Urban WRA**	**<20 WRA**	**>=20 WRA**
Median duration of partially exclusive breastfeeding	PPFP	DHS	Rural/urban, <20/>=20					
Median birth interval and/or % women with birth to pregnancy interval of at least 2 years	PPFP	DHS	Rural/urban, <20/>=20					
% of women who give birth with a skilled attendant	PPFP	DHS or MICS	Rural/urban, <20/>=20					
% of women who give birth in a health facility	PPFP	DHS or MICS	Rural/urban, <20/>=20					
% ANC visits where FP counselling occurs	PPFP	HMIS or facility surveys						
% of women delivering in facility who receive FP counselling before discharge	PPFP	HMIS or facility surveys						
% of women delivering in facility who receive FP method before discharge	PPFP	HMIS or facility surveys						
% of women attending for post-abortion or abortion care who receive FP method before discharge	PPFP	HMIS or facility surveys						
% of post-natal care clients (usually 2-6 weeks postpartum) who receive FP counselling	PPFP	HMIS or facility surveys						
% of immunization clients who receive FP counselling	PPFP	HMIS or facility surveys						
% of women delivering in facility who receive breastfeeding counselling before discharge	PPFP	HMIS or facility surveys						

Annex A4 Policy & Guidance Alignment Assessment for PPFP

Q #	Question	Prompts for question	Level of policy and guidance alignment (full/partial/none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
1	ANC policies, guidelines and tools recommend counselling on FP during at least one of the routine ANC visits				
2	Maternity or immediate post-natal care policies, guidelines and tools recommend counselling on FP in the immediate postpartum period				
3	Post-natal care policies, guidelines and tools recommend counselling on FP at the first post-natal care check-up				
4	Immunization policies, guidelines and tools recommend counselling on FP during child health checks/immunization visits				
5	MNH policies, guidelines and tools clearly state the 3 criteria for Lactational Amenorrhoea Method (LAM)	LAM criteria are i.<6 months postpartum; fully or nearly fully breastfeeding; no return of menses			
6	Infant feeding/nutrition policies, guidelines and tools clearly state the 3 criteria for Lactational Amenorrhoea Method (LAM)	LAM criteria are i.<6 months postpartum; fully or nearly fully breastfeeding; no return of menses			
7	MNH policies, guidelines and tools provide guidance on how to reach women who did not have a facility delivery with FP				
8	MNH policies, guidelines and tools encourage women to transition from LAM to another method of contraception at 6 months postpartum				

Q #	Question	Prompts for question	Level of policy and guidance alignment (full/partial/none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
9	Do policies, guidelines and tools align precisely with WHO's latest PPFP compendium and Handbook for postpartum and post-abortion FP?	Does guidance allow immediate initiation of progestogen-only pills & implants after birth? And do they allow initiation of combined and progestogen-only methods immediately post-abortion (both surgical and medical))?			
10	FP policies and guidelines align with WHO Selected Practice recommendations and WHO Handbook on initiation criteria for breastfeeding amenorrhoeic women <6 months postpartum.	Breastfeeding amenorrhoeic women less than 6 months post-partum can initiate POPs and implants at any time without need for a backup method. They can initiate DMPA between 6 weeks and 6 months postpartum without the need for a backup method.			
11	FP policies and guidelines align with WHO Selected Practice recommendations on initiation criteria for post-abortion women.	IUD/IUS can be initiated immediately after 1st and 2nd tri abortion. All progestogen-only methods and combined hormonal method can be initiated immediately post-abortion.			
12	PPFP and PAFP Policies and guidelines align with WHO's human rights framework for the provision of contraception, including on informed consent procedures, offer of range of methods, recommendations on privacy and confidentiality, and non-allowance for conscientious objection to provision of FP information and services	Review WHO Human Rights for Contraceptive Services framework			

Annex A5: Case studies summary (use one table per module)

Title of project or programme with short description (Select 2-3 case studies)	Where was the project or programme implemented? (States, regions, districts)	Who implemented it?	What were the achievements?	What were some of the health systems factors that made the project a success? (Review Bottlenecks Framework)	What were some of the challenges? (Review Bottlenecks Framework)	Any other relevant information including lessons learned?

Annex A6: Key informant Questionnaire for PPFP

WHO Family Planning Accelerator project

Bottlenecks Assessment (BNA)

KII Questionnaire – Post-pregnancy FP (PPFP)

Introduction

Who is running this assessment?

This questionnaire is part of a national 'FP Bottlenecks Assessment' being coordinated by the World Health Organization, investigating the scale-up of evidence-based practices in family planning.

What is the purpose of this questionnaire?

This questionnaire will ask about your opinions on a range of potential health systems 'bottlenecks' (or barriers or factors) that may be inhibiting scale-up of postpartum and post-abortion family planning in this country. You will be asked to rate your agreement out of 5 with a series of statements (from fully agree to fully disagree). You can also add comments about each statement if you wish. At the end, you can mention any potential barriers or challenges that have not been raised in the questionnaire.

Why am I being asked to complete it?

You have been purposefully selected as a person with considerable knowledge on postpartum and/or post-abortion family planning in this country. Your opinions will be greatly valuable for the Bottlenecks Assessment.

What happens afterwards?

A consensus-building workshop will be held with a range of different stakeholders to identify the most important bottlenecks, and to identify solutions to address them.

Is my contribution anonymous?

Everything you write in this questionnaire or tell us in person will be anonymized. We will only ask questions about your work role.

What happens if I refuse or don't have time to participate?

Nothing, please just let us know that you are not able to complete the questionnaire and we will seek another informant. There will be no impact on your employment.

Section		Q #	Preliminary questions	Circle the correct response:	Any comments
Background		**1.**	What type of organization do you work for (circle number that applies)?	1. Government 2. Professional association 3. NGO or civil society 4. Private 5. Other_____	
		2.	What is your role in that organisation (circle number that applies)?	1. Policy 2. Programme management 3. Researcher/M&E 4. Clinician or health worker 5. Other_____	
		3.	At what level to you provide support to FP programmes (circle number that applies):	1. National 2. Sub-national or regional 3. District 4. Community 5. Other_____	
		4.	How long have you been working in or supporting FP programmes (circle number that applies):	1. <1 year 2. 1-3 years 3. 3-10 years 4. >10 years	

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
Implementation status		**5.**	**Postpartum and post-abortion family planning are adequately implemented and scaled-up nationally** ***Consider these statements when rating:*** • Comprehensive FP counselling is routinely provided within ANC, post-delivery and at the post-natal check (2-6 weeks after birth) (including discussion of return to fertility, healthy timing and spacing of pregnancies, immediate and exclusive breastfeeding, contraception to use while breastfeeding, , postpartum IUD, other long-acting methods) • There are interventions in place to support women transition from LAM to other methods before 6 months postpartum. • Labour/post-natal wards routinely offer range of methods for immediate postpartum FP initiation, including progestogen-only pills, implants, and IUDs • Facilities offering safe abortion or post-abortion care offer comprehensive FP counselling to all women attending for abortion services (including methods that can be started immediately post-abortion) • PPFP is routinely offered across both public and private/NGO facilities. • PPFP is an integral component of primary health care.		
Governance	**Leadership & commitment**	**6.**	**There is strong leadership and commitment to support scale-up of postpartum and post-abortion FP.**		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			Consider these statements when rating: • There is political support for postpartum and post-abortion FP at national level • PPFP is included in national FP goals • Postpartum and post-abortion FP have champions advocating for the practices at the national level • Postpartum and post-abortion FP have champions advocating for the practices at the state/regional level • State/regional and district authorities follow the guidance of the MOPH on PPFP and do not make autonomous policies that contradict MOPH guidance. • Hospital managers and clinical directors follow the guidance of the MOPH on PPFP and do not make autonomous policies that contradict MOPH guidance.		
	Accountability	**7.**	**There is strong accountability for postpartum and post-abortion FP across institutional structures and among policy makers and programme managers** ***Consider these statements when rating:*** • There is accountability and coordination across different institutional structures (public, private and non-governmental authorities) to enable effective postpartum and post-abortion policy development and programming. • A public officer has accountability* to deliver scale-up of postpartum and post-abortion FP at national level • A public officer has accountability* to deliver scale-up of postpartum and post-abortion FP at the state/regional level		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			**Accountable means someone is responsible and answerable for the correct and thorough delivery of scale-up*		
	Regulation	**8.**	**There is strong regulation to ensure access to postpartum and post-abortion FP.** ***Consider these statements when rating:*** • There are no laws or policies that limit access to FP in the postpartum and post-abortion periods, including for unmarried or adolescent girls, or for provision of FP in post-abortion care. • There are no laws or policies that require partner consent to receive FP • There are no laws or policies that restrict access for adolescents or unmarried women. • The private/non-governmental sector is adequately regulated in its provision of PPFP.		
	Guidance formulation	**9.**	**There is sufficient guidance (including policies, guidelines and tools) to support scale up of PPFP** ***Consider these statements when rating:*** • Policy & practice guidance to support implementation of postpartum and post-abortion FP exists and is up to date. • Policy & practice guidance to support implementation of PPFP is available to all district health teams, health facilities and education establishments • There is a clear comprehensive abortion care or post-abortion care policy that includes suggested mechanisms to promote and offer post-abortion FP • Policy & practice guidance on PPFP is endorsed by the MoPH		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• International standards and guidance on PPFP have been adapted to the national and/or state context • PPFP practice guidance is standardised and does not allow for unwanted flexibility in implementation • Postpartum & post-abortion guidance is incorporated into programmatic & clinical standards, guidelines and tools		
Financing	**Budgeting**	**10.**	**There is adequate budget available at all levels to support postpartum and post-abortion FP scale up.** ***Consider these statements when rating:*** • There is a costed implementation plan for scale-up of postpartum and post-abortion FP, and they have been included in the FP2020/30 CIP • Postpartum and post-abortion FP have been included in the Global Financing Facility (GFF) Investment Case. • Adequate domestic funds are allocated to postpartum and post-abortion FP in national budgets • Adequate domestic funds are allocated to postpartum and post-abortion FP in state/regional budgets		
	Donors	**11.**	**Donors sufficiently contribute to financing scale-up of postpartum and post-abortion FP** ***Consider these statements when rating:*** • Donor priorities are aligned with MOH policies and priorities for PPFP scale-up. • Donors commitments are sufficiently financed in budgets.		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
	Insurance	**12.**	**National health insurance schemes cover access to contraceptives within post-partum and post-abortion care**		
	Spending allocation	**13.**	**Government expenditure on PPFP matches the allocated budget**		
	Planning	**14.**	**There is a coherent national plan for PPFP scale-up** ***Consider these statements when rating:*** • The extent of post-partum and post-abortion FP coverage or gaps have been mapped nationally • A strategic plan for expanding coverage of postpartum & post-abortion FP exists and has been effectively communicated, and actions are included within annual operating plans. • Potential challenges to implementation are identified and addressed proactively		
	Equity	**15.**	**There are financing mechanisms and policy actions in place to ensure equitable scale-up of PPFP access** ***Consider these statements when rating:*** • Budget is allocated to areas where rates of PPFP use are low and unmet needs for FP are high. • Budgeting and programming address the PPFP needs of adolescents and women from poor and/or rural contexts. • Programmes address the PPFP needs of other marginalized women including women living with HIV, women with disability, women from minority ethic groups and female sex workers.		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• Data are reviewed regularly to ensure equitable allocation of budget.		
People	**Communication, knowledge & awareness**	**16.**	**PPFP policies and guidance are well communicated and there is a high level of knowledge and awareness of recommended practices:** ***Consider these statements when rating:*** • There is effective national dissemination of relevant policies and guidance on postpartum and post-abortion FP. • Policy-makers & programme managers at the national and state/regional levels fully understand and know postpartum and post-abortion recommended practices • Healthcare managers and workers (public and private) fully understand and know the recommended practices on PPFP, including MNCH providers offering ANC, delivery, PNC and infant feeding support; and providers offering abortion/post-abortion care. • There are effective communication channels in place to ensure that stakeholders remain engaged and informed about PPFP activities and progress.		
	Acceptability	**17.**	**There is acceptance of recommended PPFP policies and practices by key stakeholders in the health system.** ***Consider these statements when rating:*** • Policy-makers & programme managers at national and regional/state levels fully agree with the need to scale-up postpartum & post-abortion FP		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• Senior healthcare managers fully agree with the need to scale up postpartum and post-abortion FP • Senior maternal/newborn/child health managers see postpartum FP as relevant to their work • Senior abortion and post-abortion care managers see post-abortion FP as relevant to their work • PPFP recommendations are easy for facility and community health managers to understand and implement		
	Consultation	**18.**	**Key stakeholders are adequately consulted during PPFP policy development and rollout** ***Consider these statements when rating:*** • Stakeholders have been adequately consulted during the creation of PPFP policy and practice guidance. • Groups that may be opposed to PPFP are sufficiently consulted (e.g. for religious, cultural, anti-choice reasons etc.) • There are established mechanisms for feedback, monitoring, and evaluation to ensure that the scale-up is effective and meeting the needs of clients and communities.		
	Coordination	**19.**	**There is good coordination between different stakeholders to ensure effective scale-up of PPFP** ***Consider these statements when rating:*** • National policies are effectively transferred to state/regional policies • The MOPH effectively coordinates the different public, NGO and private stakeholders in their efforts to scale-up PPFP		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• There are regular interagency meetings during the year that discuss and plan for PPFP scale-up (with participation of MoH, donors, NGOs, UN, professional associations etc.) • The FP teams in relevant MOPH departments jointly plan with the MNCH teams for postpartum and post-abortion scale-up, including with teams responsible for ANC, delivery, PNC and infant feeding support. • The MOH coordinates with private and non-governmental providers on PPFP scale-up • OB/GYN and midwifery experts participate in planning meetings to scale up PPFP.		
	Networks	**20.**	**There are effective professional networks supporting scale-up of PPFP** ***Consider these statements when rating:*** • The RH TWG prioritises and plans to support PPFP scale up • PPFP is actively and regularly promoted through professional networks. • There are active regional training networks who support scale-up of PPFP • The country has learned from other similar country contexts on how to scale-up PPFP		
	Community engagement	**21.**	**There is adequate community engagement to promote the benefits of postpartum FP and healthy birth-spacing** ***Consider these statements when rating:***		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• There are health promotion initiatives (CHWs/SBC/marketing /other community outreach) to promote healthy birth-spacing and uptake of postpartum FP • Community health programmes have strategies in place to promote and provide FP to women who do not deliver in health facilities • Post-partum women are regularly followed up at home by community health workers who actively promote PPFP and healthy birth-spacing • Facilities and district health teams work with trusted community or religious leaders to promote healthy birth spacing • There are efforts to involve men in the promotion of postpartum or post-abortion FP when women attend maternal and newborn health services • Engagement is tailored to address local social and gender norms that affect reproductive health decisions • Health facilities offering PPFP have effective client feedback and engagement mechanisms in place (surveys, suggestion boxes, review groups, etc.)		
Information	**Reporting**	**22.**	**There is adequate reporting on PPFP uptake and trends** ***Consider these statements when rating:*** • There are agreed reporting standards and key performance indicators for monitoring of postpartum and post-abortion FP • Key performance indicators on postpartum FP align with facility indicators recommended by WHO (% of postpartum women delivering in facility initiating a contraceptive method before discharge; % of postpartum women counselled on FP before discharge)		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• Data on post-abortion FP counselling and uptake is routinely collected and reported by facilities offering abortion or post-abortion care • PPFP method mix is monitored and reported • Uptake of PPFP in the extended postpartum period (up to 6 months) is monitored and reported (incl. through use of household survey data). • There is an agreed goal or target for effective postpartum and post-abortion FP coverage. • Data on postpartum and post-abortion coverage (including in public and private sector) is received and monitored at national and state/regional levels		
	Data & HMIS	**23.**	**There is an effective HMIS to support data collection on PPFP, and data on PPFP is used regularly for performance management.** ***Consider these statements when rating:*** • ANC, maternity and post-natal care registers/HMIS routinely record counselling, provision and acceptance of FP • There is a data dashboard that facilitates monitoring of district and/or facility performance on postpartum and post-abortion FP • Private providers (for profit & non-profit) offering MNH, abortion/post-abortion care or FP services are required to share PPFP data with the MOPH • Data trends on PPFP coverage and outcomes are shared with district health teams, facilities and program managers to allow regular assessment and comparison of performance • There is an effective HMIS collecting necessary datapoints to monitor implementation of postpartum & post-abortion FP nationally		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• ANC cards are routinely used to capture FP preferences and are then used postpartum • Data on PPFP is used regularly to assess and manage programming response		
	Guidelines & tools	**24.**	**Updated guidance on PPFP is available and widely used.** ***Consider these statements when rating:*** • Updated guidelines* and service protocols for postpartum and post-abortion exist and are available at all service delivery points • Updated provider job aids* for postpartum and post-abortion FP exist and are available at all service delivery points **Guidance includes latest WHO recommendation that women can start progestogen-only pills and implants immediately postpartum*		
	Client SBC/IEC	**25.**	**SBC/IEC materials on PPFP are available for use in maternal and newborn health facilities** ***Consider these statements when rating:*** • SBC/IEC materials/apps on FP for post-partum women exist and are routinely distributed and available for use or take-away in ANC, maternity, post-natal care, and newborn/child health services. • SBC/IEC materials/apps used in infant feeding and/or immunization services include information on birth-spacing or FP, including the three criteria for LAM* • SBC/IEC materials/apps on FP are routinely distributed in abortion/post-abortion care services • SBC/IEC materials on FP are available for women purchasing medical abortion from pharmacies.		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			**fully/nearly fully breastfeeding; within 6 months of delivery; amenorrhoeic*		
	Health promotion	**26.**	**There are adequate initiatives and interventions to promote the benefits of postpartum and post-abortion FP to women attending for care.** ***Consider these statements when rating:*** • There are regular efforts to promote postpartum FP in the community through health promotion/social-behaviour change communication/mass media/marketing. • Successful behavioural interventions to promote FP in ANC and post-natal care are known and scaled. • Successful behavioural interventions to promote FP uptake post-abortion are known and scaled. • Successful behavioural interventions to reach clients in the extended postpartum period are known and scaled. • Digital technology and m-health are regularly used to promote postpartum and post-abortion FP among clients with cell phones.		
Medicines & technology	**Infrastructure**	**27.**	**There is adequate infrastructure to deliver PPFP** ***Consider these statements when rating:*** • Relevant health facilities have physical infrastructure to implement postpartum and post-abortion FP, including private space for FP counselling • Maternity facilities are laid out in a way that allows immediate PP-IUD insertion or provision of other FP methods in the immediate postpartum period.		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
	Supplies	**28.**	**Health facilities have sufficient commodities, equipment and other supplies required to deliver PPFP** ***Consider these statements when rating:*** • Relevant health facilities have equipment to implement postpartum and post-abortion FP. • Relevant health facilities always have FP commodities in stock to support PPFP (including implants, IUDs, injectables, progestogen-only pills, combined pills, condoms). • Maternity and post-natal care units have the necessary equipment and supplies required for implant and IUD insertion • There is a functional logistics management information system (electronic or paper) that is able to track use of and provide maternity, post-natal care and abortion facilities with required equipment • Access to supplies and commodities is well coordinated across different actors in the health system.		
	Innovation	**29.**	**Effective innovations to support implementation of PPFP are rapidly disseminated and utilized** ***Consider these statements when rating:*** • There is funding and political/institutional commitment to test and scale innovations to support PPFP scale-up. • Innovations are tested rigorously, including through local studies when needed. • Results and insights from innovation testing are rapidly shared and disseminated to enable rapid scale-up.		
Service delivery	**Management**	**30.**	**There is effective health management to support delivery of PPFP**		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			Consider these statements when rating: • There is a designated manager in maternity/PNC and abortion/post-abortion care facilities who is accountable for PPFP uptake • Implementation of PPFP is included in management review processes of district and facility managers. • Quality control and audit processes cover implementation of PPFP • Clinical leaders advocate for and promote PPFP in their facilities • The relevant healthcare managers have sufficient capacity to manage the scale-up of PPFP • Management tools and procedures exist to support managers address constraints with implementing PPFP • Managers regularly monitor trends in PPFP uptake or outcomes to assess potential gaps • Maternity and abortion/post-abortion care mangers regularly conduct learning reviews to assess what is working well for PPFP promotion and provision, and what needs change/adaptation. • Client journey mapping /flow analysis is used to identify intervention points for PPFP & PAFP		
	Supervision	**31.**	**There is adequate clinical supervision to support PPFP** ***Consider these statements when rating:*** • All supervisors working in maternity/post-natal/abortion care have been oriented on postpartum and post-abortion FP and related service delivery provision requirements • Maternity/post-natal care and abortion/post-abortion care provider competency assessments include PPFP • Providers working in maternity/post-natal care and abortion units receive regular supervision on PPFP		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• Clinical mentorship schemes to promote and supervise PPFP exist and are widely used • There are sufficient supervisors for national scale-up of postpartum and post-abortion FP		
	Team work & coordination	**32.**	**Different teams involved in PPFP work together to ensure its delivery** ***Consider these statements when rating:*** • Maternity/PNC/abortion care teams coordinate with FP teams to deliver services together • Immunization and other child health/infant feeding teams coordinate with FP teams to deliver services together		
	Service organization & scheduling	**33.**	**Maternal health services are structured and scheduled to ensure access to PPFP** ***Consider these statements when rating:*** • FP services are integrated with other MNCH services (ANC, Labour, PPC and Immunization). • Contraception is available in labour rooms/operating theatres. • Post-natal care is routinely offered and accessed, and includes provision of FP up to 6 weeks postpartum • Maternity and OB/GYN services have capacity to offer FP on 24 hour basis		
	Referral systems	**34.**	**Referral systems between different health facility units effectively support access to PPFP** ***Consider these statements when rating:*** • There are effective referral systems from maternity, post-natal care and post-abortion care to FP services/units/departments		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• There are referral or follow up systems for women receiving medical abortion to return following abortion completion to receive post-abortion family planning • There are referral systems or other mechanisms in place to allow women purchasing medical abortion pills over the counter to receive post-abortion contraception		
	Fees	**35.**	**There are no additional fees charged to women in maternity, post-natal care and post-abortion care for taking FP**		
Human Resources	**Training & education**	**36.**	**Pre- and in-service training of health workers is adequately supporting PPFP provision** ***Consider these statements when rating:*** • Postpartum and post-abortion initiation protocols and return to fertility are included in nurse/midwife and OBGYN pre-service curricula • Training needs for postpartum and post-abortion FP are regularly assessed • In-service training curricula for postpartum and post-abortion FP exist • There are sufficient trainers to support national scale-up of the PPFP • In-service training (workshops and/or on-the-job training) on FP are regularly conducted within maternity, PNC and abortion services		
	Capacity	**37.**	**Health workers in MNH services have capacity to deliver PPFP** ***Consider these statements when rating:*** • Staff/client ratios allow maternity, post-natal care and abortion/post-abortion care staff to deliver contraception		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• Staff turnover is low enough to allow institutionalisation of new skills for PPFP scale-up		
	Roles	**38.**	**PPFP provision is included in maternity/post-natal and abortion clinical staff job descriptions**		
	Skills & competencies	**39.**	**MNH staff have the requisite skills and competencies to deliver PPFP** ***Consider these statements when rating:*** • MNH staff working in ANC, maternity and PNC have required skills for FP provision, including PP-IUD and implant insertion • MNH staff working in infant feeding have required skills for counselling on LAM and other FP methods. • MNH staff working in post-abortion care have required skills for FP provision • There are policies or efforts in place to task-share post-partum IUD and implant insertion to lower cadres of staff.		
	Motivation	**40.**	**MNH staff (working in ANC, maternity, PNC, infant care, abortion care) are motivated to provide PPFP** ***Consider these statements when rating:*** • MNH staff have positive attitude towards providing FP • Clinical supervisors and managers are supportive of postpartum and post-abortion FP provision • MNH staff are adequately remunerated for providing FP services • Quality PPFP provision is included in MNH provider performance management processes.		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• There is a supportive institutional culture that prioritises integrated health care in MNH and addressing women's holistic health needs post-pregnancy and post-abortion.		
		41.	**Are there any other challenges, barriers, or 'bottlenecks' that are inhibiting effective scale-up of postpartum and/or post-abortion FP in this country that you would like to mention?** *Enter response here:*		

Annex A7: BNA Workshop for PPFP

Workshop overview

Workshop Aims: The aim of this workshop is for the group of stakeholders to come to consensus on the most important bottlenecks inhibiting scale-up of post-pregnancy FP (PPFP) in this country, and to identify solutions to address the challenges and barriers.

Who attends: See core module for detailed list of suggested participants. Participants should include

(i) Policymakers and programme managers at national & state levels
(ii) Facility managers, clinicians, and professional association representatives
(iii) Civil Society representatives

Facilitation: The workshop should be facilitated by an experienced facilitator, as well as expert in PPFP.

Workshop timing and format: The workshop should last two days. The suggested format is as follows:

Session No.	Session Name	Session Aims	Timings
	DAY 1		
1	Introductions	For the group to know each other and break the ice	45 mins
2	PPFP overview	Expert(s) on PPFP to present key recommended evidence-based policies and practices on PPFP. With Q&A	30 mins
3	Implementation status report	Present and understand: • Policy & guideline alignment • Data review • Questionnaire findings Q&A after each	1 hr 30 mins
4	Case studies	Relevant participants to present lessons learned on EBP implementation case studies	1 hr
5	Bottlenecks framework update	Bottlenecks framework presentation Any missing bottlenecks? Q&A and update to framework	45 mins
6	Bottleneck group work: ranking	3 groups: Group 1: Governance and financing Group 2: People and information Group 3: Medicines/technology, service delivery & human resources	2 hrs

		To review BNA ranking tool (see below), discuss, and group rate importance of bottlenecks Prioritise the potential bottlenecks inhibiting PPFP scale-up Come to consensus on the top 10 bottlenecks	
	Day 2		
7	Group report back	3 groups to report back rankings	1 hr 30
8	Root cause analysis	Group work on root causes of the key bottlenecks	2 hrs 30
9	Solutions identification	Group work on solutions identification	2 hrs
10	Group report back and wrap up		1 hr 30

Session 1: Introductions

Facilitators to lead icebreaker to allow everyone to get to know each other. Facilitators to present workshop aims.

Session 2: PPFP overview

Expert(s) on PPFP to present key recommended evidence-based policies and practices on PPFP. Facilitators should review Annex 1 (above) and ensure the presentation covers recommendations on both postpartum FP and post-abortion FP.

Session 3: Implementation status report

Consultant to present their findings from the desk review and questionnaire:

- Policy & guideline alignment
- Data review
- Questionnaire findings

Allow Q&A after each presentation.

Session 4: Case studies

Participants who led or were involved in EBPP case studies to present their experiences of EBPP implementation. The presentation should focus on HOW the programme worked, i.e. what health systems factors helped or hindered the implementation process. Any relevant outcome results can also be presented.

Session 5: BNA framework update

Presentations to be followed by Q&A and group discussion and feedback on findings of the reports. Discussion on 'any missing bottlenecks?' – either not identified from original WHO framework or new ones raised during discussion.

Outcome: Consensus on current state of implementation scale-up and locally relevant bottlenecks.

Session 6: Bottlenecks ranking exercise

Split into 3 groups, ensuring a mix of participant types (policy/programme, clinical, civil society) across the three groups:

Group 1: Governance and financing

Group 2: People and information

Group 3: Medicines/technology, service delivery & human resources

Use the ranking tool (see Annex 8), groups to rate the potential bottlenecks inhibiting scale-up of PPFP. Ensure one facilitator per group. Group to elect note-taker to feed back later.

Group to consider the following (place of flipchart on wall in each group room!):

- How big of a problem is this factor in preventing scale-up of PPFP?
- If it was addressed would we see likely improvements in scale and quality of PPFP?
- Is this a problem preventing nationwide scale-up of PPFP?
- How urgently does this bottleneck need to be solved?
- How many other bottlenecks does this problem cause?

Groups to proceed as follows:

1) Facilitators to present the prioritisation sheets and encourage group to read the potential bottlenecks at each level (the DETAIL is important!).
2) Group participants to first individually rank the 10-14 bottlenecks they have been allocated, in terms of priority factors inhibiting scale-up of PPFP. (1=least important)
3) Facilitators to display all the 10-14 sub-categories on flipcharts, and ask everyone to come and write their ranked number against each sub-category.
4) Facilitators to calculate an average ranking score for each bottleneck factor and summarise the top ranked 5 factors.
5) Facilitator to ask for 'voices of dissent' to set out their case for bottlenecks that are missing from the top 5 or which have been prioritised at a low level.
6) Group to come to consensus through discussion on the final top 5 priority bottlenecks.

Group 1: Governance & Financing	**Group 2: People & Information**	**Group 3: Medicines/technology, service delivery & HR**
Governance: • Leadership & commitment • Accountability • Regulation • Guidance formulation & coherence **Financing** • Budgeting • Donors • Insurance • Spending • Planning • Equity	**People:** • Communication, knowledge & awareness • Acceptability • Consultation • Coordination • Networks • Community engagement **Information** • Reporting • Data & HMIS • Guidelines & tools • Client SBC/IEC • Health promotion	**Medicines & technology:** • Infrastructure • Supplies & LMIS • Innovation **Service delivery:** • Management • Supervision • Team work • Service structure & scheduling • Referral systems • Fees **Human Resources:** • Training & education • Capacity • Roles • Skills & competencies • Motivation
Total no. of potential bottlenecks: 10	**Total no. of potential bottlenecks: 11**	**Total no. of potential bottlenecks: 14**

Outcome: Groups have identified 5 important bottlenecks to present to the workshop on Day 2 (15 altogether across the 3 groups)

Facilitators *to write up the 15 top bottlenecks onto a flipchart using large post-it notes (so they can be moved/edited if needed) before session 7.*

Session 7: Group report back and final ranking

Each group to report back on its work, including the types of factors they discussed, the bottleneck ranking, and the rationale for the most important bottlenecks chosen.

Ask the wider group to reflect on what they find surprising or interesting in the rankings. Ask again for 'voices of dissent' for any important bottlenecks that have not been prioritised by other groups.

Once there is consensus on the final 15 bottlenecks, edit the flipcharts to make sure all 15 are displayed.

Give each participant 9 gold stars (or other coloured sticker). Ask them to consider all their discussions and place a gold star on each bottleneck that they would like to discuss solutions for in the next session. Remind them of the five key questions:

- How big of a problem is this factor in preventing scale-up of PPFP?
- If it was addressed would we see likely improvements in scale and quality of PPFP?
- Is this a problem preventing nationwide scale-up of PPFP?
- How urgently does this bottleneck need to be solved?
- How many other bottlenecks does this problem cause?

Also ask them to consider a 6th question:

- Can this bottleneck actually be resolved with careful planning and resource-allocation?

Once that has been completed, the facilitators highlight or circle the final 9 factors (bottlenecks) for solutions planning. Ask the group to any final voices of dissent along with justified pleas for swapping.

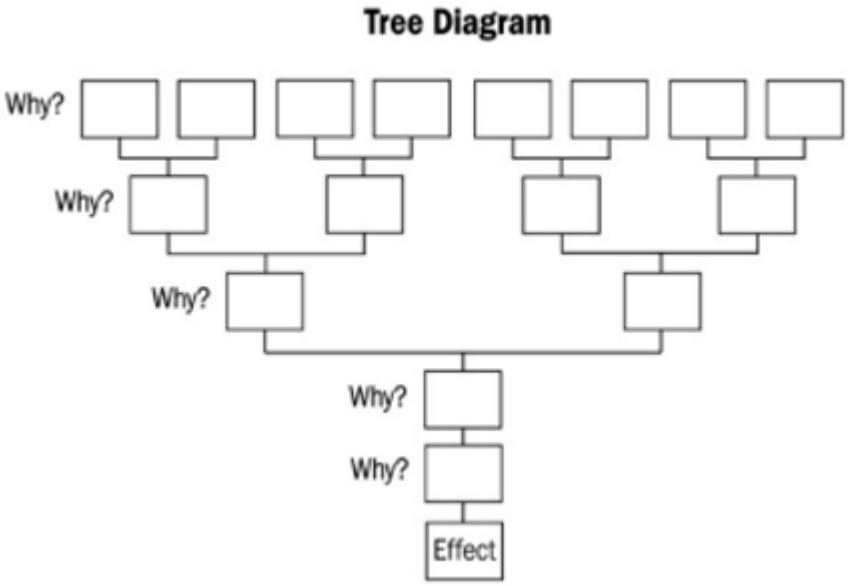
Session 8: Root cause analysis

Divide the large group into three again. The groups can be kept the same or mixed again, depending on dynamics/need.

Divide up the 9 bottlenecks (3-3-3), and either ask participants to select a specific group, or allocate them into groups. Ensure groups are mixed representation again.

Ask each group to develop a 'Problem tree' for each of their 3 bottlenecks. First write the effect (i.e. the bottleneck), and then ask **The 5 Why's** to analyze the root cause of the bottleneck and some solutions. As the diagram shows, there may be multiple reasons, and they should find the root cause of as many as possible!

Figure 1: Root Cause Analysis, URC/USAID Assist Project



Example Root cause analysis

If the group chose 'Accountability' , the group might brainstorm as follows in one branch of the tree (but do all branches during the workshop!):

Effect: There is no accountability for PPFP in the MOPH (national and state)

Question 1: **Why** is there no accountability for PPFP in the MOPH?

Answer 1: Because PPFP falls between the cracks of the Family Planning Unit and the Maternal Health Unit.

Question 2: **Why** does PPFP fall between the cracks of the FP and MNH units?

Answer 2: Because nobody has it in their job description?

Question 3: **Why** does nobody have it in their job description?

Answer 3: Because nobody in senior management realises that PPFP isn't being addressed?

Question 4: **Why** does nobody in senior management realise that PPFP isn't being addressed?

Answer 4: Because PPFP is not reported as a national KPI for the family planning or MNH departments.

Question 5: **Why** is PPFP not reported as a national KPI in the FP and MNH departments?

Answer 5: Because there is no data and because the MOH is not required to report it to the UN.

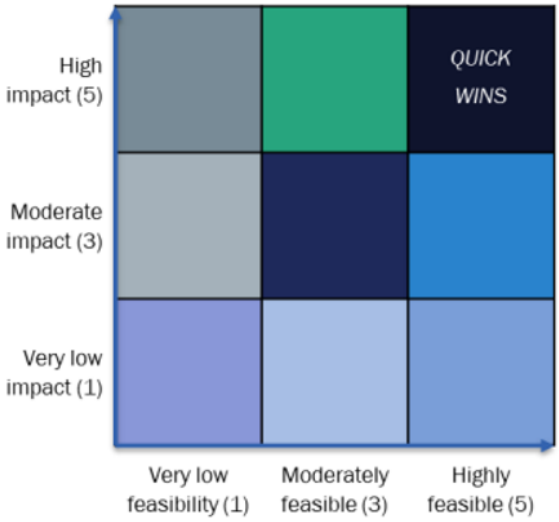
Session 9: Solutions identification

After a break, ask the groups to reconvene to discuss solutions based on their root cause analysis. In the example above, the solutions might be:

1) Work with the relevant Ministry director to agree on a national KPI for PPFP
2) Work with the HMIS division to develop and test a workable PPFP indicator, requiring national reporting and accountability.

When discussing solutions, try and focus on 'quick wins' – actions that are both highly feasible and likely to have high impact. Feasibility should consider costs, cost-effectiveness and available budgets. Impact should consider likely health and health system outcomes, equity and sustainability.

Figure 2: Impact feasibility matrix, Health Policy Plus



As solutions are discussed and agreed, enter them into the **solutions grid** (see next page) (paper or digitally on laptop), and suggest people/groups/organizations who can support in implementing solutions.

Session 10: Report back and wrap up

The three groups should present back their root cause analyses and solutions planning. Note areas of common root causes and/or solutions across the groups. Ask the broader group for comment after report back. Build consensus on final solutions identified. .

Discuss next steps required for dissemination and ensure interested and relevant stakeholders are engaged in the process.

PPFP Bottlenecks Solutions Grid

Proposed solution	Which bottleneck does it address?	Check: How feasible is this solution?*	Check: How impactful will this solution be?	Which organizations can support with this solution?	Other comments

**consider available budget, time and funding*

Annex A8: PPFP Bottlenecks Ranking Tool

This tool is to be used during the group work in the BNA PPFP workshop. There are 3 tables for the 3 groups:

1) Governance & Financing
2) People & Information
3) Medicines & Technology / Service Delivery / Human Resources

PPFP Workshop Group 1: Governance & Financing

Groups to use this sheet to rank the potential bottlenecks that are inhibiting scale-up of POSTPARTUM AND POST-ABORTION FP (PPFP).

***10 is the most important bottleneck, 1 is the least important**

BNA Framework Theme	Categories (10 potential bottlenecks)	Group to consider these statements and then rank how important is this bottleneck *10 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
Governance	**Leadership & commitment**	**There is strong leadership and commitment to support scale-up of postpartum and post-abortion FP.** ***Consider these statements when rating:*** • There is political support for postpartum and post-abortion FP at national level • PPFP is included in national FP goals • Postpartum and post-abortion FP have champions advocating for the practices at the national level • Postpartum and post-abortion FP have champions advocating for the practices at the state/regional level • State/regional and district authorities follow the guidance of the MOPH on PPFP and do not make autonomous policies that contradict MOPH guidance. • Hospital managers and clinical directors follow the guidance of the MOPH on PPFP and do not make autonomous policies that contradict MOPH guidance.		
	Accountability	**There is strong accountability for postpartum and post-abortion FP across institutional structures and among policy makers and programme managers** ***Consider these statements when rating:*** • There is accountability and coordination across different institutional structures (public, private and non-governmental authorities) to enable effective postpartum and post-abortion policy development and programming. • A public officer has accountability* to deliver scale-up of postpartum and post-abortion FP at national level • A public officer has accountability* to deliver scale-up of postpartum and post-abortion FP at the state/regional level **Accountable means someone is responsible and answerable for the correct and thorough delivery of scale-up*		

BNA Framework Theme	Categories (10 potential bottlenecks)	Group to consider these statements and then rank how important is this bottleneck *10 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
	Regulation	**There is strong regulation to ensure access to postpartum and post-abortion FP.** ***Consider these statements when rating:*** • There are no laws or policies that limit access to FP in the postpartum and post-abortion periods, including for unmarried or adolescent girls, or for provision of FP in post-abortion care. • There are no laws or policies that require partner consent to receive FP • There are no laws or policies that restrict access for adolescents or unmarried women. • The private/non-governmental sector is adequately regulated in its provision of PPFP.		
	Guidance formulation	**There is sufficient guidance (including policies, guidelines and tools) to support scale up of PPFP** ***Consider these statements when rating:*** • Policy & practice guidance to support implementation of postpartum and post-abortion FP exists and is up to date. • Policy & practice guidance to support implementation of PPFP is available to all district health teams, health facilities and education establishments • There is a clear comprehensive abortion care or post-abortion care policy that includes suggested mechanisms to promote and offer post-abortion FP • Policy & practice guidance on PPFP is endorsed by the MoPH • International standards and guidance on PPFP have been adapted to the national and/or state context • PPFP practice guidance is standardised and does not allow for unwanted flexibility in implementation • Postpartum & post-abortion guidance is incorporated into programmatic & clinical standards, guidelines and tools		
Financing	**Budgeting**	**There is adequate budget available at all levels to support postpartum and post-abortion FP scale up.** ***Consider these statements when rating:*** • There is a costed implementation plan for scale-up of postpartum and post-abortion FP, and they have been included in the FP2020/30 CIP • Postpartum and post-abortion FP have been included in the Global Financing Facility (GFF) Investment Case.		

BNA Framework Theme	Categories (10 potential bottlenecks)	Group to consider these statements and then rank how important is this bottleneck *10 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• Adequate domestic funds are allocated to postpartum and post-abortion FP in national budgets • Adequate domestic funds are allocated to postpartum and post-abortion FP in state/regional budgets		
	Donors	**Donors sufficiently contribute to financing scale-up of postpartum and post-abortion FP** ***Consider these statements when rating:*** • Donor priorities are aligned with MOH policies and priorities for PPFP scale-up. • Donors commitments are sufficiently financed in budgets.		
	Insurance	**National health insurance schemes cover access to contraceptives within post-partum and post-abortion care**		
	Spending allocation	**Government expenditure on PPFP matches the allocated budget**		
	Planning	**There is a coherent national plan for PPFP scale-up** ***Consider these statements when rating:*** • The extent of post-partum and post-abortion FP coverage or gaps have been mapped nationally • A strategic plan for expanding coverage of postpartum & post-abortion FP exists and has been effectively communicated, and actions are included within annual operating plans. • Potential challenges to implementation are identified and addressed proactively		
	Equity	**There are financing mechanisms and policy actions in place to ensure equitable scale-up of PPFP access** ***Consider these statements when rating:*** • Budget is allocated to areas where rates of PPFP use are low and unmet needs for FP are high. • Budgeting and programming address the PPFP needs of adolescents and women from poor and/or rural contexts. • Programmes address the PPFP needs of other marginalized women including women living with HIV, women with disability, women from minority ethic groups and female sex workers. • Trend data are reviewed regularly to ensure equitable allocation of budget.		

PPFP Workshop Group 2: People & Information

Groups to use this sheet to rank the potential bottlenecks that are inhibiting scale-up of POSTPARTUM AND POST-ABORTION FP.

***11 is the most important bottleneck, 1 is the least important**

BNA Framework Theme	Categories (11 potential bottlenecks)	Group to consider these statements and then rank how important is this bottleneck *11 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
People	**Communication, knowledge & awareness**	**PPFP policies and guidance are well communicated and there is a high level of knowledge and awareness of recommended practices:** ***Consider these statements when rating:*** • There is effective national dissemination of relevant policies and guidance on postpartum and post-abortion FP. • Policy-makers & programme managers at the national and state/regional levels fully understand and know postpartum and post-abortion recommended practices • Healthcare managers and workers (public and private) fully understand and know the recommended practices on PPFP, including MNCH providers offering ANC, childbirth, PNC and infant feeding support; and providers offering abortion/post-abortion care. • There are effective communication channels in place to ensure that stakeholders remain engaged and informed about PPFP activities and progress.		
	Acceptability	**There is acceptance of recommended PPFP policies and practices by key stakeholders in the health system.** ***Consider these statements when rating:*** • Policy-makers & programme managers at national and regional/state levels fully agree with the need to scale-up postpartum & post-abortion FP • Senior healthcare managers fully agree with the need to scale up postpartum and post-abortion FP • Senior maternal/newborn/child health managers see postpartum FP as relevant to their work • Senior abortion and post-abortion care managers see post-abortion FP as relevant to their work • PPFP recommendations are easy for facility and community health managers to understand and implement		

BNA Framework Theme	Categories (11 potential bottlenecks)	Group to consider these statements and then rank how important is this bottleneck *11 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
	Consultation	**Key stakeholders are adequately consulted during PPFP policy development and rollout** ***Consider these statements when rating:*** • *Stakeholders have been* adequately consulted during the creation of PPFP policy and practice guidance. • Groups with potential opposition to PPFP are sufficiently consulted (e.g. religious, cultural, anti-choice etc.) • There are established mechanisms for feedback, monitoring, and evaluation to ensure that the scale-up is effective and meeting the needs of clients and communities.		
	Coordination	**There is good coordination between different stakeholders to ensure effective scale-up of PPFP** ***Consider these statements when rating:*** • National policies are effectively transferred to state/regional policies • The MOPH effectively coordinates the different public, NGO and private stakeholders in their efforts to scale-up PPFP • There are regular interagency meetings during the year that discuss and plan for PPFP scale-up (with participation of MoH, donors, NGOs, UN, professional associations etc.) • The FP teams in relevant MOPH departments jointly plan with the MNCH teams for postpartum and post-abortion scale-up, including with teams responsible for ANC, childbirth, PNC and infant feeding support. • The MOH coordinates with private and non-governmental providers on PPFP scale-up • OB/GYN and midwifery experts participate in planning meetings to scale up PPFP.		
	Networks	**There are effective professional networks supporting scale-up of PPFP** ***Consider these statements when rating:*** • The RH TWG prioritises and plans to support PPFP scale up • PPFP is actively and regularly promoted through professional networks. • There are active regional training networks who support scale-up of PPFP		

BNA Framework Theme	Categories (11 potential bottlenecks)	Group to consider these statements and then rank how important is this bottleneck *11 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• The country has learned from other similar country contexts on how to scale-up PPFP		
	Community engagement	**There is adequate community engagement to promote the benefits of postpartum FP and healthy birth-spacing** ***Consider these statements when rating:*** • There are health promotion initiatives (CHWs/SBC/marketing /other community outreach) to promote healthy birth-spacing and uptake of postpartum FP • Community health programmes have strategies in place to promote and provide FP to women who do not deliver in health facilities • Post-partum women are regularly followed up at home by community health workers who actively promote PPFP and healthy birth-spacing • Facilities and district health teams work with trusted community or religious leaders to promote healthy birth spacing • There are efforts to involve men in the promotion of postpartum or post-abortion FP when women attend maternal and newborn health services • Engagement is tailored to address local social and gender norms that affect reproductive health decisions • Health facilities offering PPFP have effective client feedback and engagement mechanisms in place (surveys, suggestion boxes, review groups, etc.)		
Information	**Reporting**	**There is adequate reporting on PPFP uptake and trends.** ***Consider these statements when rating:*** • There are agreed reporting standards and key performance indicators for monitoring of postpartum and post-abortion FP • Key performance indicators on postpartum FP align with facility indicators recommended by WHO (% of postpartum women delivering in facility initiating a contraceptive method before discharge; % of postpartum women counselled on FP before discharge) • Data on post-abortion FP counselling and uptake is routinely collected and reported by facilities offering abortion or post-abortion care • PPFP method mix is monitored and reported		

BNA Framework Theme	Categories (11 potential bottlenecks)	Group to consider these statements and then rank how important is this bottleneck *11 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• Uptake of PPFP in the extended postpartum period (up to 6 months) is monitored and reported (incl. through use of household survey data). • There is an agreed goal or target for effective postpartum and post-abortion FP coverage. • Data on postpartum and post-abortion coverage (including in public and private sector) is received and monitored at national and state/regional levels		
	Data & HMIS	**There is an effective HMIS to support data collection on PPFP, and data on PPFP is used regularly for performance management.** ***Consider these statements when rating:*** • ANC, maternity and post-natal care registers/HMIS routinely record counselling, provision and acceptance of FP • There is a data dashboard that facilitates monitoring of district and/or facility performance on postpartum and post-abortion FP • Private providers (for profit & non-profit) offering MNH, abortion/post-abortion care or FP services are required to share PPFP data with the MOPH • Data trends on PPFP coverage and outcomes are shared with district health teams, facilities and program managers to allow regular assessment and comparison of performance • There is an effective HMIS collecting necessary datapoints to monitor implementation of postpartum & post-abortion FP nationally • ANC cards are routinely used to capture FP preferences and are then used postpartum • Data on PPFP is used regularly to assess and manage programming response		
	Guidelines & tools	**Updated guidance on PPFP is available and widely used.** ***Consider these statements when rating:*** • Updated guidelines* and service protocols for postpartum and post-abortion exist and are available at all service delivery points • Updated provider job aids* for postpartum and post-abortion FP exist and are available at all service delivery points		

BNA Framework Theme	Categories (11 potential bottlenecks)	Group to consider these statements and then rank how important is this bottleneck *11 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		**Guidance includes latest WHO recommendation that women can start progestogen-only pills and implants immediately postpartum*		
	Client SBC/IEC	**SBC/IEC materials on PPFP are available for use in maternal and newborn health facilities** ***Consider these statements when rating:*** • SBC/IEC materials/apps on FP for post-partum women exist and are routinely distributed and available for use or take-away in ANC, maternity, post-natal care, and newborn/child health services. • SBC/IEC materials/apps used in infant feeding and/or immunization services include information on birth-spacing or FP, including the three criteria for LAM* • SBC/IEC materials/apps on FP are routinely distributed in abortion/post-abortion care services • SBC/IEC materials on FP are available for women purchasing medical abortion from pharmacies. **fully/nearly fully breastfeeding; within 6 months of delivery; amenorrhoeic*		
	Health promotion	**There are adequate initiatives and interventions to promote the benefits of postpartum and post-abortion FP to women attending for care.** ***Consider these statements when rating:*** • There are regular efforts to promote postpartum FP in the community through health promotion/social-behaviour change communication/mass media/marketing. • Successful behavioural interventions to promote FP in ANC and post-natal care are known and scaled. • Successful behavioural interventions to promote FP uptake post-abortion are known and scaled. • Successful behavioural interventions to reach clients in the extended postpartum period are known and scaled. • Digital technology and m-health are regularly used to promote postpartum and post-abortion FP among clients with cell phones.		

PPFP Workshop Group 3: Medicines & Technology / Service Delivery / Human Resources

Groups to use this sheet to rank the potential bottlenecks that are inhibiting scale-up of POSTPARTUM AND POST-ABORTION FP.

***14 is the most important bottleneck, 1 is the least important**

BNA Framework Theme	Categories (14 potential bottlenecks)	Group to consider these statements and then rank how important is this bottleneck *14 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
Medicines & Technology	**Infrastructure**	**There is adequate infrastructure to deliver PPFP** ***Consider these statements when rating:*** • Relevant health facilities have physical infrastructure to implement postpartum and post-abortion FP, including private space for FP counselling • Maternity facilities are laid out in a way that allows immediate PP-IUD insertion or provision of other FP methods in the immediate postpartum period.		
	Supplies	**Health facilities have commodities, equipment and other supplies required to deliver PPFP** ***Consider these statements when rating:*** • Relevant health facilities have equipment to implement postpartum and post-abortion FP. • Relevant health facilities always have FP commodities in stock to support PPFP (including implants, IUDs, injectables, progestogen-only pills, combined pills, condoms). • Maternity and post-natal care units have the necessary equipment and supplies required for implant and IUD insertion • There is a functional logistics management information system (electronic or paper) that is able to track use of and provide maternity, post-natal care and abortion facilities with required equipment • Access to supplies and commodities is well coordinated across different actors in the health system.		
	Innovation	**Effective innovations to support implementation of PPFP are rapidly disseminated and utilized** ***Consider these statements when rating:*** • There is funding and political/institutional commitment to test and scale innovations to support PPFP scale-up. • Innovations are tested rigorously, including through local studies when needed.		

BNA Framework Theme	Categories (14 potential bottlenecks)	Group to consider these statements and then rank how important is this bottleneck *14 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• Results and insights from innovation testing are rapidly shared and disseminated to enable rapid scale-up.		
Service delivery	**Management**	**There is effective health management to support delivery of PPFP** ***Consider these statements when rating:*** • There is a designated manager in maternity/PNC and abortion/post-abortion care facilities who is accountable for PPFP uptake • Implementation of PPFP is included in management review processes of district and facility managers. • Quality control and audit processes cover implementation of PPFP • Clinical leaders advocate for and promote PPFP in their facilities • The relevant healthcare managers have sufficient capacity to manage the scale-up of PPFP • Management tools and procedures exist to support managers address constraints with implementing PPFP • Managers regularly monitor trends in PPFP uptake or outcomes to assess potential gaps • Maternity and abortion/post-abortion care mangers regularly conduct learning reviews to assess what is working well for PPFP promotion and provision, and what needs change/adaptation. • Client journey mapping /flow analysis is used to identify intervention points for PPFP & PAFP		
	Supervision	**There is adequate clinical supervision to support PPFP** ***Consider these statements when rating:*** • All supervisors working in maternity/post-natal/abortion care have been oriented on postpartum and post-abortion FP and related service delivery provision requirements • Maternity/post-natal care and abortion/post-abortion care provider competency assessments include PPFP • Providers working in maternity/post-natal care and abortion units receive regular supervision on PPFP • Clinical mentorship schemes to promote and supervise PPFP exist and are widely used • There are sufficient supervisors for national scale-up of postpartum and post-abortion FP		

BNA Framework Theme	Categories (14 potential bottlenecks)	Group to consider these statements and then rank how important is this bottleneck *14 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
	Team work & coordination	**Different teams involved in PPFP work together to ensure its delivery** ***Consider these statements when rating:*** • Maternity/PNC/abortion care teams coordinate with FP teams to deliver services together • Immunization and other child health/infant feeding teams coordinate with FP teams to deliver services together		
	Service organization & scheduling	**Maternal health services are structured and scheduled to ensure access to PPFP** ***Consider these statements when rating:*** • FP services are integrated with other MNCH services (ANC, Labour, PPC and Immunization). • Contraception is available in labour rooms/operating theatres. • Post-natal care is routinely offered and accessed, and includes provision of FP up to 6 weeks postpartum • Maternity and OB/GYN services have capacity to offer FP on 24 hour basis		
	Referral systems	**Referral systems between different health facility units effectively support access to PPFP** ***Consider these statements when rating:*** • There are effective referral systems from maternity, post-natal care and post-abortion care to FP services/units/departments • There are referral or follow up systems for women receiving medical abortion to return following abortion completion to receive post-abortion family planning • There are referral systems or other mechanisms in place to allow women purchasing medical abortion pills over the counter to receive post-abortion contraception		
	Fees	**There are no additional fees charged to women in maternity, post-natal care and post-abortion care for taking FP**		
Human Resources	**Training & education**	**Pre- and in-service training of health workers is adequately supporting PPFP provision** ***Consider these statements when rating:*** • Postpartum and post-abortion initiation protocols and return to fertility are included in nurse/midwife and OBGYN pre-service curricula		

BNA Framework Theme	Categories (14 potential bottlenecks)	Group to consider these statements and then rank how important is this bottleneck *14 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• Training needs for postpartum and post-abortion FP are regularly assessed • In-service training curricula for postpartum and post-abortion FP exist • There are sufficient trainers to support national scale-up of the PPFP • In-service training (workshops and/or on-the-job training) on FP are regularly conducted within maternity, PNC and abortion services		
	Capacity	**Health workers in MNH services have capacity to deliver PPFP** ***Consider these statements when rating:*** • Staff/client ratios allow maternity, post-natal care and abortion/post-abortion care staff to deliver contraception • Staff turnover is low enough to allow institutionalisation of new skills for PPFP scale-up		
	Roles	**PPFP provision is included in maternity/post-natal and abortion clinical staff job descriptions**		
	Skills & competencies	**MNH staff have the requisite skills and competencies to deliver PPFP** ***Consider these statements when rating:*** • MNH staff working in ANC, maternity and PNC have required skills for FP provision, including PP-IUD and implant insertion • MNH staff working in infant feeding have required skills for counselling on LAM and other FP methods. • MNH staff working in post-abortion care have required skills for FP provision • There are policies or efforts in place to task-share post-partum IUD and implant insertion to lower cadres of staff.		
	Motivation	**MNH staff (working in ANC, maternity, PNC, infant care, abortion care) are motivated to provide PPFP** ***Consider these statements when rating:*** • MNH staff have positive attitude towards providing FP • Clinical supervisors and managers are supportive of postpartum and post-abortion FP provision • MNH staff are adequately remunerated for providing FP services		

BNA Framework Theme	Categories (14 potential bottlenecks)	Group to consider these statements and then rank how important is this bottleneck *14 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• Quality PPFP provision is included in MNH provider performance management processes. • There is a supportive institutional culture that prioritises integrated health care in MNH and addressing women's holistic health needs post-pregnancy and post-abortion.		

PPFP Bibliography

1. WHO. *Programming strategies for postpartum family planning*. https://www.who.int/publications-detail-redirect/9789241506496 (2013).
2. USAID. *High Impact Practices in Family Planning (HIPs). Immediate Postpartum Family Planning Counseling and Services*. https://www.fphighimpactpractices.org/briefs/immediate-postpartum-family-planning/ (2022).
3. Cleland, J., Conde-Agudelo, A., Peterson, H., Ross, J. & Tsui, A. Contraception and health. *The Lancet* **380**, 149–156 (2012).
4. WHO. *Abortion care guideline*. https://www.who.int/publications-detail-redirect/9789240039483 (2022).
5. WHO. *Family Planning. A Global Handbook for Providers.* https://www.who.int/publications/i/item/9780999203705 (2018).
6. Mumah, J. N., Machiyama, K., Mutua, M., Kabiru, C. W. & Cleland, J. Contraceptive Adoption, Discontinuation, and Switching among Postpartum Women in Nairobi's Urban Slums. *Stud Fam Plann* **46**, 369–386 (2015).
7. FP2030. *Postpartum Family Planning Indicators for Routine Monitoring in National Health Management Information Systems*. https://fp2030.org/sites/default/files/Our-Work/ppfp/PPFP_indicator_recommendations_FINAL_2019_0.pdf (2019).