



## Costed Implementation Plan Resource Kit

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# Guidance for Developing a Technical Strategy for Family Planning Costed Implementation Plans

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# Overview of the Guide

## About this Guide

This guide is part of a series of resources in the Costed Implementation Plan (CIP) Resource Kit. It is intended to provide systematic and practical guidance for articulating the family planning (FP) goal, results, strategic priorities, and implementation plan (also referred to as activity matrices)—which together make up the CIP technical strategy—for a country (or district, region, or state). The processes described in this guide are based on the experience of Technical Support Teams (TSTs) who have provided assistance to over 30 countries to develop CIPs, and incorporates known methodical frameworks for project design and strategic planning, including the logical framework approach and the results framework. It was originally published in 2015 and updated in 2018.

## Intended Users of the Guide

The development of a CIP is a highly participatory process, involving a range of stakeholders and technical experts. This guide is primarily intended for use by TSTs, who provide support during CIP development and execution planning, but may not necessarily be involved in execution of the plan. The TST works in close collaboration with one or more Strategy Advisory Groups (SAGs)—seasoned experts in key FP technical areas. The TST receives guidance and oversight from a CIP Task Force, which represents the governance and decision-making body of the CIP development process. The composition, roles, and responsibilities of different teams and individuals are described in the [Team Roles and Responsibilities for CIP Development and Execution document](#).

## How to Use the Guide

This guide aims to promote consistency and clarity throughout the CIP process, while allowing for the flexibility to tailor the process to different country contexts. It can be adapted for use to develop CIPs at the subnational level— for example, at the state or district level. This guide begins with an introduction in which three action steps for developing a CIP are briefly presented. Following the introduction, each action step is presented in more detail, including a description of the step (the “what”) followed by recommendations for how to implement the action step (the “how”). The action steps are color-coded for easy navigation. The guide also includes several tools, templates, and other guidance resources recommended for use throughout the CIP development process. Tools are included as either Web-based links or appendices.

To foster a country-owned, government-led plan, the CIP technical strategy should be developed through an inclusive, locally-driven approach. In this guide, specific opportunities that necessitate engaging stakeholders are discussed in detail. Broad guidance on how to engage stakeholders in the overall CIP process is found in another guide in this series, [Stakeholder Engagement for Family Planning Costed Implementation Plans](#).

The TST leading development of a CIP should plan to write-up the technical narrative during the steps described in the guide, rather than waiting until the end of the process. **Appendix 1** provides a sample table of contents to help structure the technical strategy document.

# Introduction

## Overview of a CIP Technical Strategy

A Costed Implementation Plan (CIP) for family planning (FP) is a concrete, multi-year action plan for achieving the goal(s) of a FP program for a country, state, county, or district. A CIP details a technical strategy and associated costs necessary to meet goal(s). The technical strategy component of a CIP articulates the FP goal(s), measurable results and a comprehensive implementation plan outlining how and when results will be achieved. The implementation plan comprises priority, evidence-based interventions and time-phased activities to be executed over the duration of the CIP. The word “strategy” should not be interpreted to mean a high-level overview describing an entire FP program (that is, vision and goal). Rather, it is used here to depict a comprehensive and interlinked set of strategic, tactical, and operational actions that encompass a CIP. This document describes the content that should be included in the technical strategy and approaches for developing that content, while other documents and tools provide guidance for conducting the costing of a CIP.

## Basis of a CIP Technical Strategy

The CIP technical strategy hinges on a comprehensive understanding of the FP issues, gaps, and opportunities at the service delivery, program, and policy levels. It follows the fundamental elements of sound FP program design. There are various frameworks for FP program design, including those listed below.

- *The Supply–Enabling Environment–Demand (SEED)™ Programming Model* (EngenderHealth)
- *Elements of Success in FP Programming* (Richey & Salem, 2008)
- *Conceptual Framework for Family Planning and Reproductive Health Programs* (MEASURE Evaluation)
- *The WHO Health Systems Framework* – although not specific to FP, it provides a good framework for project design (World Health Organization, 2010)

## Process Overview

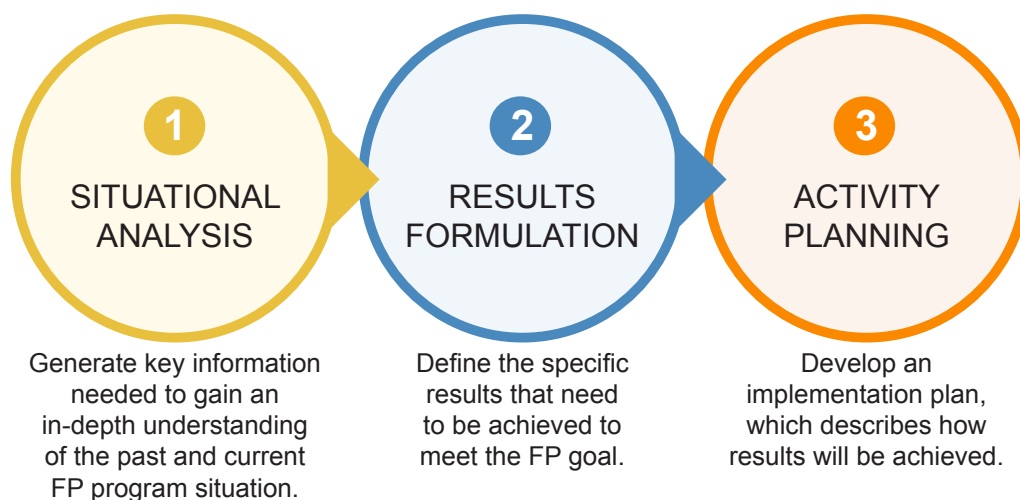
Developing a CIP technical strategy corresponds to Step 3 (Conduct a Situational Analysis) and Step 4 (Develop a Technical Strategy) of the 10-step CIP process (Figure 1). The process for developing a technical strategy follows three action steps: situational analysis, results formulation, and activity planning (Figure 2).

The first action step, situational analysis, generates information on opportunities, key issues or problems, and associated causal factors surrounding the FP program. The second action step, results formulation, uses information from the situational analysis to generate results expressed as the FP goal, outcomes, and outputs. It also estimates measurable targets to be achieved for each result and begins to define the indicators to be tracked during performance monitoring in the execution phase. The third and last action step, activity planning, generates an implementation plan or set of activity matrices which delineate how and when the results will be achieved. A number of countries have used (or plan to use) the FP Goals Model during the CIP development process. This

**Figure 1: 10 Steps for Building a Family Planning CIP**

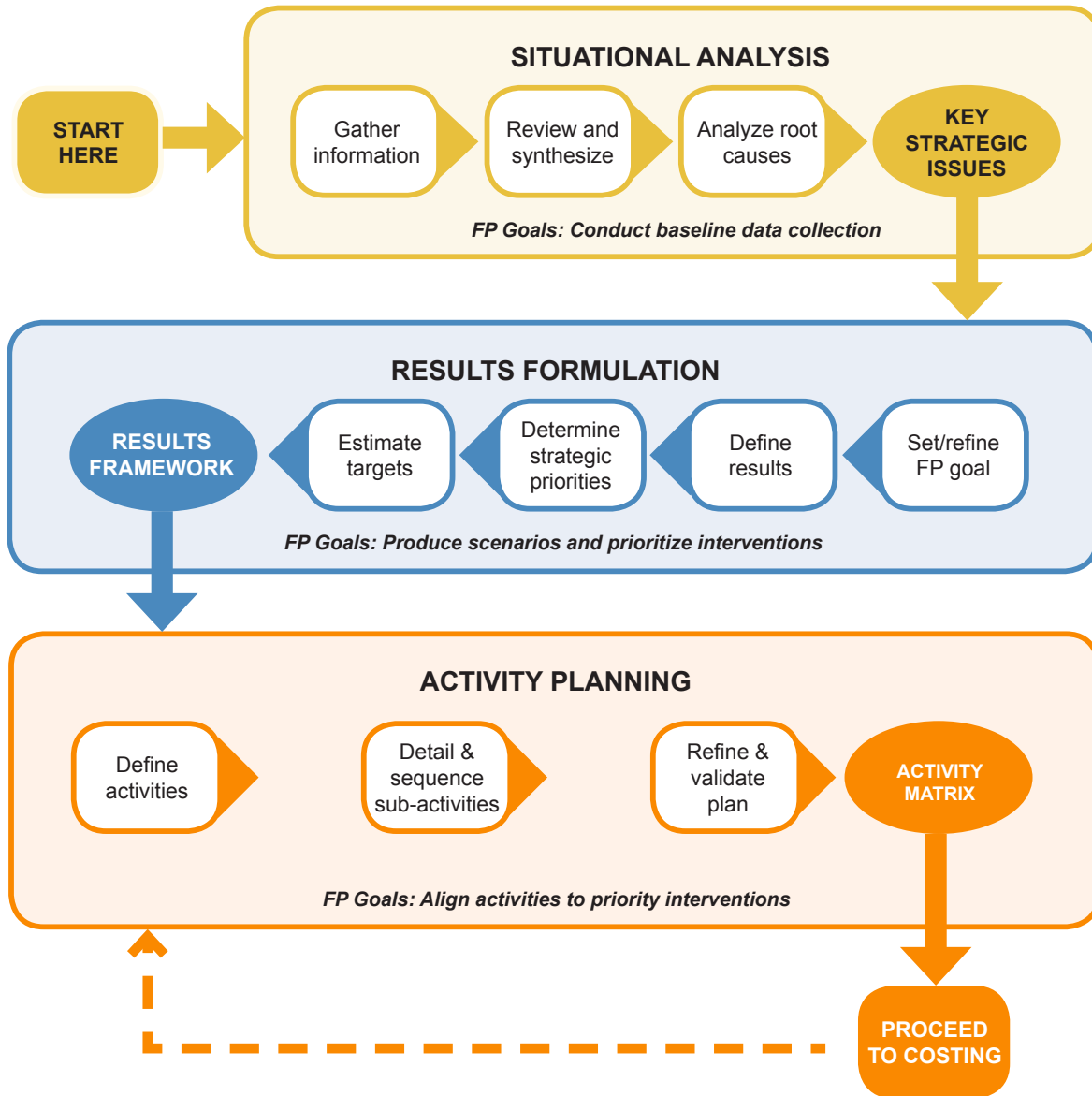


**Figure 2: Three Action Steps for Developing a CIP Technical Strategy**



model, developed by Avenir Health’s Track20 Project, combines demographic data, FP program information, and evidence of the effectiveness of diverse interventions to help decision-makers set realistic goals and prioritize investments across different FP interventions. See **Appendix 2** for a description of how the model was incorporated into the development of Tanzania’s second CIP. Depending on the country context (for example, size and diversity) and scope of the CIP (national or subnational), the time taken to develop a technical strategy can range from 6 to 12 months. Figure 3 provides the process map to illustrate the sub-steps involved under each of the three action steps.

Figure 3: Process Map for Developing a CIP Technical Strategy





# Three Action Steps for Developing a CIP Technical Strategy

## Action Step 1: SITUATIONAL ANALYSIS

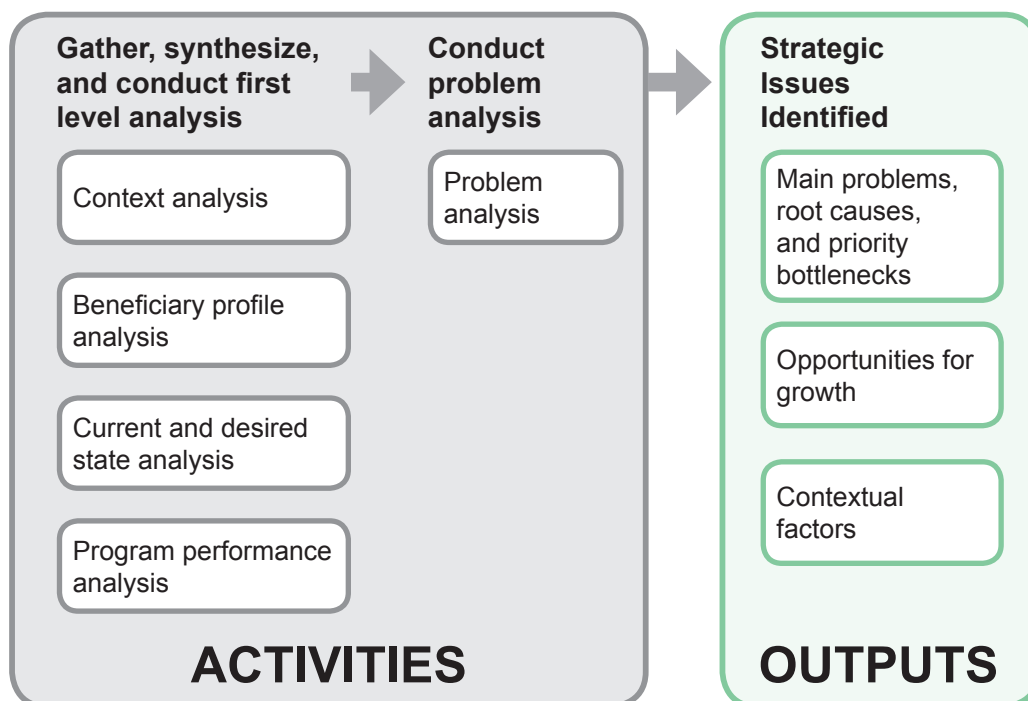
### What is a Situational Analysis?

A situational analysis involves the systematic collection, review, and analysis of information and data from various sources on the past and current status of the FP program. It provides a solid understanding of the factors that drive and block progress towards achieving the country's FP goal, and the basis for developing the CIP technical strategy. This action step is the most important in the CIP technical strategy development process, as it forms the foundation upon which subsequent action steps build, providing an opportunity to “diagnose” the problems and identify relevant, evidence-based results and activities.

#### a) Analytical Framework

The situational analysis should be as rigorous and data-driven as possible, utilizing multiple sources to triangulate and validate available data and applying several analyses to better understand the challenges that the FP program must address. The output from the situational analysis process is a set of key strategic issues that includes major problems plaguing the FP program and associated root causes, historical data and projections for the future, and a solid understanding of contextual factors that can both limit and/or accelerate growth. An analytical framework (**Figure 4**) helps to conceptually organize the situational analysis process and to ensure a comprehensive diagnosis of the FP program that extends across sectors and levels of the health system.

**Figure 4: Analytical Framework for a Situational Analysis**



## b) First-Level Analyses

1. **Context analysis:** Refers to the analysis of the political/policy/legal, economic, and socio-cultural context within which the FP program operates.

**a. Political, policy, and legal environment:** A supportive policy environment—the formulation and implementation of appropriate laws and policies and the allocation of sufficient resources—is critical for the success of FP programs and facilitates the development of an enabling environment. Supportive laws, policies, and strategies can influence the mobilization of financial and technical resources for program implementation and service delivery. A supportive policy environment usually requires political commitment, or the decision of and action from government leaders to use their power, influence, and personal involvement to ensure that FP programs receive the visibility, leadership, resources, and ongoing political support that is required to meet the country’s FP goals (HIP 2013).

**b. Economic environment:** This refers to the economic factors that affect individual contraceptive use and the country’s ability to meet the contraceptive needs of its population. Understanding the economic environment requires exploring national and subnational economic and financing priorities vis-à-vis FP (for example, whether the national priority is infrastructure spending to modernize industrialization or health spending to improve workforce performance), financing trends, and financing sources (including from both public and private sectors, and both domestic and foreign investments).

**c. Social environment:** This refers to the social determinants, including culture, religion, and gender norms, which are acknowledged to influence individual use and community acceptance of FP. Understanding these social determinants and their influence in a given context can help to understand barriers, target program design, and select specific interventions.

2. **Beneficiary profile analysis:** This refers to the analysis of the beneficiary population to generate a profile of FP users and potential users (current non-users), with the aim of answering the question: “Who are the people the FP program is intending to serve?” The profile takes into account the demographic profile and demographic trends of the beneficiary population (age, education, socio-economic status, religion, residence—urban/rural), as well as fertility and contraceptive use preferences.

Given that the population of women and men of reproductive age (the primary beneficiary group for FP programs) is vast and

### BOX 1 Profile of Female Users of Modern Contraceptives in Nigeria

Nearly one in four users of modern FP (38%) are ages 25-34, and that about two out of every three (63%) are married or cohabiting. Nearly one in three users of modern FP methods have no living children, which suggests that they are using these methods to delay the onset of childbearing. Breakdown according to women’s desire for additional children shows that only 28% of users of modern contraception report they do not want to have any more children. The large majority of modern contraceptive users are Christian (79%) and live in the southern regions (70%). A large proportion of modern contraceptive users (63%) live in urban areas and have secondary or higher education (74%). Classification according to the International Wealth Index indicates that most users of modern contraceptives are middle class: Only 5% are considered very poor and only 14% are wealthy. Among current users of modern contraception, the condom is the most common method (41% of users), followed by injectables (22%) and the pill (17%). Nearly two out of every three (63%) users of modern FP reported that they last obtained the method from a private sector source (including NGOs).

diverse, beneficiary profile analysis attempts to identify the profiles and needs of various segments and sub-segments of the beneficiary population. These could include young people (ages 10-14, 15-19, and 20-24; in-school and out-of-school; married and unmarried), postpartum women, urban vs. rural populations, users by method and by source of method (private vs. public). This type of analysis should also examine relative sizes of the different segments of the beneficiaries to be served to help identify the largest potential in terms of increasing contraceptive use. A refined understanding of the beneficiary population helps to better select program interventions. **Box 1** provides an example of a condensed beneficiary profile for one of the segments of populations to be served—women currently using modern contraceptives—using several commonly used stratification variables gleaned from the DHS, including age, marital status, fertility (number of surviving children), fertility preferences, religion, region, type of place of residence (rural/urban) and level of education (NPC Nigeria and IFC International, 2014). The *FP Goals Model* baseline data collection and analysis includes this type of segmentation.

3. **Current/desired state analysis:** This refers to the analysis of the current state of FP and the desired state of FP, to understand the extent of the gap that needs to be addressed in the CIP. This is relevant for countries that already have specific FP goals documented—whether in country development or health strategies, investment cases, FP2020 commitments or elsewhere—and provides an opportunity for stakeholders to understand what type of annual progress will be required to reach the goal(s). Scenarios for making the transition to the desired state are based on current and historical trends. This allows stakeholders to also understand the pace required to close the gap and may lead stakeholders to decide to alter a previously set FP program goal if it appears that the required pace is not feasible. Countries that plan to conduct the full *FP Goals Model* exercise will go through this type of exercise for certain indicators, including modern contraceptive prevalence rate (mCPR) and method mix. **Table 1** below provides an example of a current/desired state analysis of goals.

**Table 1 | Example of Current/Desired State Analysis Matrix**

Indicator	Current State 2016	Desired State 2020	Required Annual Growth Estimate (If applicable), percentage points	Historical Trends (Annual Growth/Decline) 2016 vs. 2010
Total Fertility Rate	6.2	5.7	-0.1	-0.08
Modern Contraceptive Prevalence	45%	52%	1.4	0.6
Unmet Need	15%	6%	-1.8	-1
Total Demand	70%	89%	3.8	2.4
Teenage Pregnancy	20%	10%	-0.02	-0.01
Method Mix   LARC Uptake	Implants: (4.2%)	Implants (10.1%)	Implants (1.18)	Implants (0.02)
	IUDs: (1.7%)	IUDs (3.9%)	IUDs (0.44)	IUDs (0.01)
Government Financing for FP (as part of national budget)	0.8%	1.20%	0.24	0.15

4. **Program performance analysis:** This refers to the analysis of how the FP program, including both public and private sectors, is currently performing. It includes identifying program strengths and weaknesses that need to be leveraged or addressed to achieve the country's goal(s). During program performance analysis, information is gathered on all facets of the program, and can be organized in numerous ways. For example, it can be presented as supply, demand, and enabling environment, as is the case with the *SEED Programming Model*. Another option is to present it by the thematic areas commonly identified in many CIPs: demand, service delivery, contraceptive commodity security, and enabling environment. Service delivery may be further broken down into categories: public and private sector, facility- and community-based services, human resources/capacity-building, and special populations (for example, youth). The enabling environment may be analyzed in terms of financing, policy, and management/accountability. If needed, the analysis can also include a sub-national focus at the district, regional, or provincial levels. Countries which plan to use the full *FP Goals Model* exercise will conduct the exercise for a range of service delivery channels (for example, public sector clinics, community health workers, private pharmacies).

## How do we do a Situational Analysis?

The situational analysis involves two major tasks: a) gathering and synthesizing information and conducting multiple analyses (discussed above) and b) conducting a problem analysis to generate root causes and to select key bottlenecks. These activities can be time-consuming, so it is advisable that a team performs them, rather than one individual.

### a) Gather and Synthesize Information and Conduct First Level Analyses

The TST uses several methods—including desk reviews, stakeholder analysis, secondary data analysis, and expert consultations—to gather quantitative and qualitative information from various sources. The sequence of data collection and analyses may vary depending on the context. However, it is highly recommended that the TST first completes the desk review, stakeholder analysis, and secondary data analysis, prior to starting expert consultations. Information from these initial efforts can then be brought to the attention of the experts for further clarification and in-depth brainstorming. First-level analyses include the context analysis, beneficiary profile analysis, current and desired state analysis, and program performance analysis. It is helpful if the first three are done first so that the information collected can inform and focus the scope of the program performance analysis. Collectively, this information will drive the problem analysis.

**Appendix 3** provides illustrative guiding questions that the TST should attempt to answer during each component of the situational analysis. It also includes suggested additional resources. The *SEED Assessment Guide* includes guides for conducting desk reviews and questionnaires for key informant interviews with a variety of stakeholders. Because key informant interviews can be time consuming, group expert consultations—also proven to encourage discussion and consensus on issues—can also be used (see **Box 2** next page for more on conducting expert consultations).

## BOX 2 Conducting Expert Consultations

Group expert consultations, through Strategy Advisory Groups (SAGs), have been shown to encourage discussion and consensus on issues among stakeholders. They have also been more time efficient than individual expert consultations, although individual consultations often must be conducted with specific organizations to gather additional information about their current and planned programs, as well as to reach specific high-level experts (such as parliamentarians or ministers) who may not be appropriate to include in larger group consultations. Careful selection of the right mix of people in each group is important to achieve stakeholder representation, and to ensure that the people invited are well versed in the subject. *The Developing CIPs: Team Roles and Responsibilities* tool describes in more detail the composition and roles of the SAGs.

Stakeholder analysis refers to the analysis of stakeholder expectations, concerns, and contributions to the national FP program. A basic premise of stakeholder engagement is that different groups have different concerns, capacities, and interests—and that these need to be explicitly understood and, when appropriate, reflected in the process of issue identification and results formulation. For group consultations, the TST convenes a series of expert meetings on specific topics that they identify as needing input, including the previously noted thematic areas (contraceptive security, service delivery, demand, and enabling environment). The TST may also choose to convene specific stakeholder groups such as youth, rural women, men, healthcare providers, or regional government health officers, depending on the context of the country or subnational area. The *Stakeholder Engagement for Family Planning Costed Implementation Plans* tool provides detailed guidance on this process.

Depending on the country context, online surveys can be used to complement face-to-face consultations. These can be particularly useful for engaging a more diverse group of stakeholders when time and financial constraints limit in-person consultations to a single geographic area (often the state or regional capital). The mix of in-person and distance consultations will vary from context to context.

During the information gathering process, the TST will collect baseline data useful for the different analyses mentioned above, as well as the *FP Goals Model* (if that is being applied), and for setting targets in Action Step 2. Common sources of baseline data included DHS, PMA2020, MICS, Track20, local HMIS systems, facility surveys, and partner reports. As part of the data collection process, the TST should make an effort to include indicators that illustrate the strength of the country's adherence to a rights-based approach to FP (see **Box 3**).

## BOX 3 FP2020 Rights and Empowerment Principles

The global FP community, via FP2020, has identified a set of 10 principles that should be at the center of FP policies and programs in order to best meet the reproductive health needs of men and women around the world. These principles are:

- Agency and autonomy
- Availability
- Accessibility
- Acceptability
- Quality
- Empowerment
- Equity and non-discrimination
- Informed choice
- Transparency and accountability
- Voice and participation

FP2020 has many resources available on their website to support countries as they strive to strengthen a rights-based approach. Among these is *Proposed Indicators to Measure Adherence to and Effects of Rights-Based Family Planning*, which can assist in collecting data during the situational analysis to demonstrate areas of strength and weakness in a country's FP program.

Throughout this process, the TST will be collecting and documenting opportunities for growth. For example, the beneficiary profile analysis may identify that there is a large population of young, married couples who could be served by the program. Thus, interventions targeting this population—like specific SBCC campaigns or postpartum FP (PPFP) programs that encourage healthy timing and spacing of pregnancies—present an opportunity for growth. Existing data analyses like those from Track20 and FP2020 also highlight opportunities for growth. Similarly, the TST will document contextual factors that need to be kept in the forefront during planning and execution of the FP program, and that may shape the ability of a country to meet its goals. Contextual factors tend to be out of the control of the national FP program (for example, the Ministry of Health or implementing partners) and may include the economic context, human resource availability, urbanization, or policy regarding sexual health education and services in schools. These are most likely to come up during the context analysis.

As the TST collects information, it also reviews and systematically classifies the information into key issues under a set of thematic areas and sub-areas. During the information gathering stage, causal factors as well as recommendations for solutions may arise and should also be classified accordingly. The *Standard Elements Checklist* provides more information on the CIP thematic areas. See **Appendix 4** for the “Issues and Solutions Matrix” template, which can be used to classify information.

### b) Conduct a Problem Analysis

The content in the Issues and Solutions Matrix will be just that—a combination of problems, causes and solutions. When all issues and solutions have been classified under thematic areas and sub-areas, the TST works with stakeholders to define and agree on the major problems facing the FP program under each thematic area. It is important to clearly articulate the problem statement as it forms the basis for the problem analysis. A good problem statement:

- Is specific enough to be measurable;
- Is not a symptom or cause of a larger problem; and
- Does not reflect a solution or lack of a solution (for example, the problem statement is not “We don’t have facilities with integrated youth-friendly services.” Instead, it may be: “Young people are getting pregnant because of lack of access to FP services,” for **K4Health Toolkits for FP** which facilities with integrated youth-friendly services may be one element of the overall solution).

As the TST sorts through the problems, some may need to be set aside, including those that are not within the purview of the FP program (related to larger contextual factors) or those problems which, if solved, would result in an immaterial effect on the FP goal.

Once major problems have been identified for each thematic area, the TST involves stakeholders, usually in the form of the SAGs, in the problem analysis exercise to define the root causes of the major problems and to select key bottlenecks to the success of the FP program from among the root causes.

A root-cause analysis (RCA) of problems involves generating root causes, and associated causal linkages, of the problems identified during the information gathering and synthesis process. There are various approaches to finding the root causes of a problem; two are described in **Appendix 5**. RCA is done in a group setting with stakeholders and relies upon the data collected, synthesized, and analyzed in the first step of this process in order to balance against conjecture or simple stakeholder opinion. The RCA informs the development of the results framework and helps build a shared sense of understanding, purpose, and action among stakeholders—which is necessary for future CIP execution.

Given the complexity of many FP program problems and challenges, an RCA for a particular problem can result in multiple, linked root causes. This is appropriate and helps stakeholders subsequently develop comprehensive solutions that are reflected as different activities in Action Step 3. However, it is recommended that the TST guide SAG members through a process of identifying major bottlenecks from among specific root causes. For example, stakeholders in the SAG for contraceptive security in a given country may have identified last mile distribution of commodities as a key problem with several root causes including weak logistics management and information system (LMIS), limited logistics management capacity within local government authorities, and insufficient vehicles for distribution. They may identify the weak LMIS as the major bottleneck based on data from a pilot project that focused on strengthening the LMIS in three districts and that demonstrated significant reductions in stock-outs at the lowest-level facilities. These bottlenecks subsequently inform the selection of strategic priorities and key results which is further described under Action Step 2.

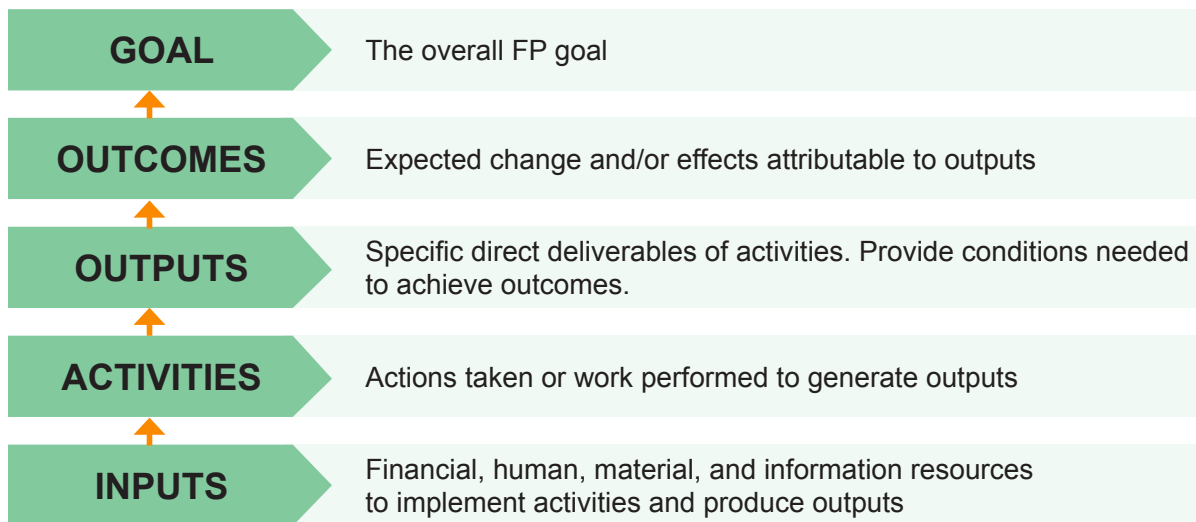
At the completion of Action Step 1, stakeholders and the TST should have a comprehensive description of the problems and their associated root causes, with highlighted key bottlenecks and a list of opportunities for growth. They will also have identified key contextual factors that are meant to keep things in perspective, regarding their influence over how the problems can be resolved. The TST will have collected key baseline information on a range of indicators and issues that will be used in subsequent action steps. If the country will engage in an *FP Goals Model* application, there are additional, specific baseline data points that will be collected. The TST is encouraged to write-up the relevant sections of the technical narrative, per the sample table of contents in **Appendix 1**.

## Action Step 2: RESULTS FORMULATION

### What is Results Formulation?

With the problems diagnosed and articulated, various analyses conducted, and baseline information in hand, stakeholders can now engage in a process of generating and prioritizing results to develop a roadmap for achieving desired goals. In this guide, we use the CIP results framework approach to develop and describe the roadmap. Other frameworks—such as a logical framework or an outcome logic model—can also be used. After generating a results framework, stakeholders can then identify and mark strategic priorities (also called key results). At the completion of this action step, they can also develop a CIP map.

A results framework is a comprehensive blueprint of the country's plan to achieve its FP goals, and describes the logical path by which resources (referred to collectively as inputs) are converted into outputs, outcomes, and the highest-level desired goal. A "result" is defined as a measurable (qualitative or quantitative) change that is derived from addressing the cause-and-effect relationship of key problems and associated causal factors. The goal is the long-term result the CIP intends to achieve, whereas outcomes and outputs are shorter-term results. A result chain is organized around an outcome (each thematic area may have more than one outcome), and has several outputs, activities, and inputs. Several result chains, together, form a results framework. As illustrated in **Figure 5**, results at each level aggregate to contribute to results at the next, higher level. A sample of a results framework with six result chains is provided in **Appendix 6**.

**Figure 5: Results Framework**

A CIP map is a one-page graphical diagram that displays key results to be achieved, and how they work together across thematic areas to contribute to the achievement of the overall goal of the CIP. An example of a CIP map is included as **Appendix 7**. A CIP map differs from the results framework in that it only displays **key results**, a subset of all the results (outcomes and outputs) included in the results framework. Key results refer to select CIP results that reflect the desired consequence of: (1) addressing bottlenecks that were identified during problem analysis and/or (2) putting in place enabling factors that accelerate achievement of the result in question. These results are considered priorities for enhanced oversight and performance monitoring during CIP execution and are identified through stakeholder consultations during CIP development. The CIP map also functions as a visualization tool for communicating CIP priorities to different stakeholders.

## How do you Formulate and Visualize Results?

The formulation of a results framework involves three tasks in the following order: (a) setting or refining the FP goal; (b) defining and prioritizing outcomes and outputs (results); and (c) estimating performance targets for results, including commodity requirements. A complete results framework includes a set of result chains, in which each chain represents a logical path from inputs to goal, and all results can be measured by a clearly defined qualitative/quantitative target. The development of activities is described in Action Step 3.



### a) Set or Refine FP Goal

The FP goal describes the main overall result of the national FP program. It sets the premise for the intensity of activities to be carried out, dictates the timeframe of the implementation plan, and informs projections for commodities and the number of people to reach with services. For the CIP, it is important to use a metric that is: (1) realistic—can reasonably be attained within the specified period and confines of available resources and (2) able to meaningfully inform projections of the number of all women that need to be reached with services to meet the overall goal. If a country must surpass historical trends to reach the FP goal, it is important to clearly articulate the reasoning behind the goal and how it is both ambitious and achievable. An unrealistic goal may result in an impractical plan that cannot be implemented with the available time and resources and can exaggerate cost estimates.

Modern CPR (for all or only married women), unmet need, and couple of years of protection (CYP) are the most commonly-used metrics for defining FP goals. It is important to carefully consider which metric to use, because each one has strengths and limitations (further described in **Appendix 8**). We generally recommend using mCPR for all women, which is the indicator tracked by FP2020 and Track20.

**When a FP goal is set**—for example, in an existing health or development strategy or as part of FP2020 or other global commitments—the TST should have reviewed the feasibility of the goal as part of the current and desired state analysis conducted during the situational analysis (Action Step 1). The TST also reviews the goal to ensure that it uses the appropriate metric, and is also specific, measurable, achievable, realistic, and time-bound (SMART). In a situation where a goal may need to be adjusted, and if stakeholders are open to making changes, the TST can provide analytical data and recommendations to inform decision-making by the government. Sometimes this means adding a secondary goal. The *FP Goals Model* can also be a useful tool for demonstrating the feasibility of a FP goal to stakeholders, and may be helpful in revising that goal. (The *FP Goals Model* was used in this way during the development of the second CIP in Tanzania, as described in **Appendix 2**).

**When there is not yet a specific FP goal**, it is necessary to conduct consultations and projection exercises to identify one. Tools such as *Reality √* and *FamPlan* can be used to forecast over-all contraceptive prevalence rates (CPRs) at national or local levels. The *Family Planning Estimation Tool (FPET)* provides annual projected estimates over time. Further, the *FP Goals Model* can determine a realistic goal as part of the CIP development process. As noted previously, the *FP Goals Model* uses a variety of data from the country, or sub-national level, to project what mCPR is reasonable in a given timeframe as a result of implementing evidence-based interventions at different levels of scale.

Once the FP goal is set, the TST uses projection tools to forecast: (1) the required annual rate of change in CPR to reach the goal (done in current and desired state analysis); (2) regional, state, or district level goals, if required; and (3) the number of people the FP program will need to serve over time. The TST also uses the beneficiary profile generated during the situational analysis to get a broad sense of the different types of people the program will serve (for example, that a majority of women of reproductive age are in rural areas or that a quarter are under the age of 19 and not married). This exercise helps stakeholders to consider a balanced set of interventions that addresses the needs of diverse population segments. Again, in countries that are applying the *FP Goals Model*, the exercise will result in projections of numbers of users to be reached, by profile and by specific intervention area, along with method mix projections and commodity requirements.

## b) Define Results and Prioritize Outcomes and Outputs

Outcomes and outputs are derived from the key problems and causal factors, as well as opportunities, identified in the situational analysis. As explained in Action Step 1, the situational analysis will generate a comprehensive list of interconnected causal factors mapped for each key problem. The TST then works with the SAGs to convert problems and associated causal factors into results, as follows:

- (i) **Convert problems/causes to results.** Under each technical area, the key problems/causal factors are re-framed as results/positive achievements. The key problems are converted to high-level results (usually the CIP goal) while causal factors become outcomes and outputs (see **Table 2** for an example). Note that this conversion is not merely a language translation, but requires identifying evidence-based interventions. The TST facilitates brainstorming sessions with the SAGs to generate a set of outputs and interventions that comprehensively addresses the problems. When this process is completed, the TST and stakeholders should have one or more result chains for each technical area (that is, demand, service delivery, contraceptive commodity security, and enabling environment). Service delivery may be further broken down to public and private sector, facility- and community-based services, human resources/capacity-building, and special populations (for example, youth). Enabling environment may be analyzed in terms of financing, policy, and management/accountability.

**Table 2 | Illustrated Conversion of Problems into Results**

Key Problems/Causal Factors	Results/Positive Achievements
<p><b>Problem</b> High rates of teenage pregnancy</p>	<p><b>Result</b> Reduced rates of teenage pregnancy</p>
<p><b>Causal factors</b></p> <ul style="list-style-type: none"> <li>• Poor access to FP services among young people (10-24 years of age)</li> <li>• Young people lack knowledge on how to prevent unintended pregnancies</li> <li>• Community-based programs are not youth-friendly</li> <li>• Coverage of the youth-friendly service approach is low, so young people find it difficult to access services</li> </ul>	<p><b>Outcomes</b></p> <ul style="list-style-type: none"> <li>• Increased access to contraception among young people</li> <li>• Young people are knowledgeable about FP</li> <li>• Coverage of youth-friendly services is increased at facility and community levels</li> </ul>
<ul style="list-style-type: none"> <li>• Behavior change campaigns are not targeting young people</li> <li>• Ministry of education policies are not favorable towards FP education in schools</li> <li>• Adolescent guidelines and policies are outdated</li> <li>• Providers in facilities respond negatively to young people who seek FP services</li> </ul>	<p><b>Outputs</b></p> <ul style="list-style-type: none"> <li>• A communication strategy is developed and implemented to ensure honest, accurate, clear, and consistent FP messaging that targets young people</li> <li>• Ministry of education policies are revised to allow the school health curriculum to include messages on sexual and reproductive health (SRH), including prevention of teenage pregnancy</li> <li>• Adolescent SRH guidelines and policies are updated</li> <li>• Providers/staff are sensitized and trained to offer adolescent-friendly services using a whole-clinic approach</li> <li>• Confidentiality and audio/visual privacy are ensured within service-delivery settings</li> </ul>

Often, outcomes require interventions that cut across different technical areas. For example, the outcome “increased knowledge and use of contraception among young people” will consist of interventions that cut across the thematic areas of service delivery, demand creation, policy, and the enabling environment. Such outcomes can be placed in the thematic area that aligns most with the outcome, with a clear description of how different interventions contribute to it. For this outcome example, demand creation may be the most appropriate thematic area.

(ii) **Validate the result chains:** While defining the results, the TST reviews the quality of each result chain. A good result chain should be:

- **Results-oriented:** Results should be expressed using “change” language in past tense (examples of “change” language are: improved, increased, and decreased).
- **Causally linked:** There should be clear “if...then” connections among outputs and outcomes. For example, “if” we implement a communication strategy targeting young people, “then” we will increase their knowledge of FP, which will “then” lead to increased use of contraception among young people.
- **Evidence-based:** The result chain should be based on evidence about what has worked in the past, taking into account lessons learned together with evaluation and research evidence. Vast information on FP evidence-based practices is available from multiple sources, some of which are listed in **Box 4**. The TST and SAGs should be familiar with these resources before formulating the results and activities. Further, if a country is applying the *FP Goals Model*, broad evidence-based intervention areas will be identified that can be incorporated into the result chains to address the problems and causal factors.
- **Unambiguous:** Results, especially outcomes, often cover very broad areas (for example, “policy environment improved”). As such, during execution and performance monitoring, they can end up as an umbrella for various unrelated interventions without a strategic focus. Therefore, to prevent ambiguity, try to express results in an explicit and specific manner. For example, the outcome can describe the desired change of policy improvement (in other words, they should answer the so-what question), such as “policy environment is made increasingly conducive to facilitate increased access to family planning services by young people.”
- **Reasonably complete:** There should be sufficient outputs to construct logical connections, but not so many that the result chain becomes overly complex. For example: Will updating adolescent guidelines and policies—and sensitizing providers on adolescent-friendly services—lead to increased coverage of adolescent-friendly services at facility and community levels? If not, what else needs to be done? Additional outputs could include: (1) vouchers provided to young people to subsidize the cost of contraceptive services or (2) community-based interventions targeting parents and caregivers implemented. Therefore, to complete the task, the group may revise statements, add new outputs if these seem to be relevant and necessary to achieve the outcome, and/or delete outputs that do not seem suitable or necessary.

At the end of steps (i) and (ii), the TST and stakeholders should have a complete results framework, composed of several validated result chains. Although the TST will already have worked with stakeholders to ensure the selected problems root-causes are feasible, within the control of the FP program, relevant, and evidence-based, it is possible that some outputs may be less feasible or impactful than others. It is also possible that implementing the totality of multiple outputs may not be feasible or practical given limited time and resources. The next step, therefore, involves prioritization to ensure that only the most impactful and feasible interventions are included in the plan.

(iii) **Prioritize outputs and interventions.** Outputs represent the deliverable/result of implementing an intervention(s). The results framework should feature outputs that can be realistically achieved and able to make an impact towards the FP goal. Further, the interventions leading up to the outputs need to be feasible, relevant for the country or subnational context, and evidence-based. The TST engages with the SAGs (through one or more meetings or consultations) to prioritize outputs and interventions, and revises the results framework to reflect this prioritization.

The *Prioritization Matrix Tool*, described in **Appendix 9**, can help stakeholders make decisions by weighing specific interventions against a set of criteria. To use this approach, the SAGs consider the specific intervention that would be linked to each output and then assess it against pre-defined criteria—namely, impact and feasibility—giving it a score and mapping it on a matrix. In most cases, the intervention linked to an output is fairly clear. For example, for the output “A communication strategy is developed and implemented to ensure honest, accurate, clear, and consistent FP messaging that targets young people,” the intervention would be “develop a communication strategy targeting young people.” However, if multiple interventions are possible for one output, they should all be listed and assessed against criteria. Based on the score and location on the matrix, SAG members then make decisions about whether, and to what extent, to retain the output and related intervention.

If a country is applying the *FP Goals Model*, then certain high-level interventions will already have been suggested, based on their potential to positively impact mCPR growth. The *FP Goals Model* uses evidence to help inform decisions on what interventions should be prioritized by estimating how much impact scaling up each intervention could have on growth in modern contraceptive use. Although the evidence behind the intervention areas in the *FP Goals Model* is clear, applying the prioritization matrix can help to consider the contextual factors which may impede successful execution. Furthermore, because the *FP Goals Model* intervention areas are quite broad, they will need to be broken down into more specific interventions. For example, PPFp is one of the *FP Goals Model* intervention areas, which includes: (1) immediate PPFp service provision, (2) integration of FP into immunization services, and (3) FP counseling to postpartum women at the community level via community health workers. These three service delivery approaches to PPFp can have very different levels of feasibility within one country and thus should be considered separately in order to make choices. The *FP Goals Model* intervention areas must also be matched with, and integrated into, the result chains.

During the discussions within SAGs, stakeholders should feel free to discuss priorities beyond impact or feasibility. A specific output or linked intervention may be considered a priority because it is already identified in a national strategy document or as part of FP2020 commitments, because it aligns to other high-priority government activities, because it presents opportunities for cost-efficiencies, or because it reflects a guiding principle such as equity or rights.

## BOX 4 Additional Resources for FP Interventions

<b>High Impact Practices (HIPs)</b>	<u>HIPs</u> are promising or evidence-based practices that, when scaled up and institutionalized, will maximize investments in a comprehensive FP strategy. Identified by international experts in FP and reproductive health, HIPs help FP programs focus their resources and efforts to ensure they have the broadest reach and greatest impact.
<b>Elements of FP Success</b>	This <u>report</u> outlines the top 10 elements most important to the success of FP programs. It synthesizes online discussions about these elements and highlights program experiences, best practices, and evidence-based guidance derived from nearly six decades in international FP.
<b>K4Health Toolkits for FP</b>	This <u>collection</u> of toolkits provides quick and easy access to relevant and reliable information on various FP topics. The resources in Toolkits are selected by experts and arranged for practical use.

### C) Select Strategic Priorities (Key Results)

Once the results framework has been developed, the TST should select strategic priorities, also called key results, for focused implementation and financial resource allocation, and for enhanced oversight and performance monitoring during CIP execution. While the earlier prioritization exercise helped to identify outputs that should be included in the results framework—based on certain criteria such as the impact and feasibility of implementing specific interventions—this exercise aims to identify a smaller number of results, from the entire results framework, that will be monitored on a frequent basis (usually quarterly). It is recommended that each outcome within the results framework have one or two outputs that are selected as key results (although this is up to the discretion of the TST).

When the *FP Goals Model* is applied, interventions identified as high impact within the model—and related outcomes and outputs—are included as strategic priorities. Stakeholders may decide that other outputs beyond those related to the *FP Goals Model* should be identified as strategic priorities, based on additional criteria discussed previously, such as promoting rights and equity or achieving cost-efficiencies. Key results should be related to outputs that address the bottlenecks identified during the problem analysis in Action Step 1 or that can answer the question, “Which outputs, when achieved, will accelerate achievement of the desired outcome?” It is important to ensure that the selected outputs reflect those over which the FP program has direct control or influence. **Table 3** next page provides a framework for considering prioritization based on multiple criteria.

**Table 3 | Criteria for Strategic Priorities**

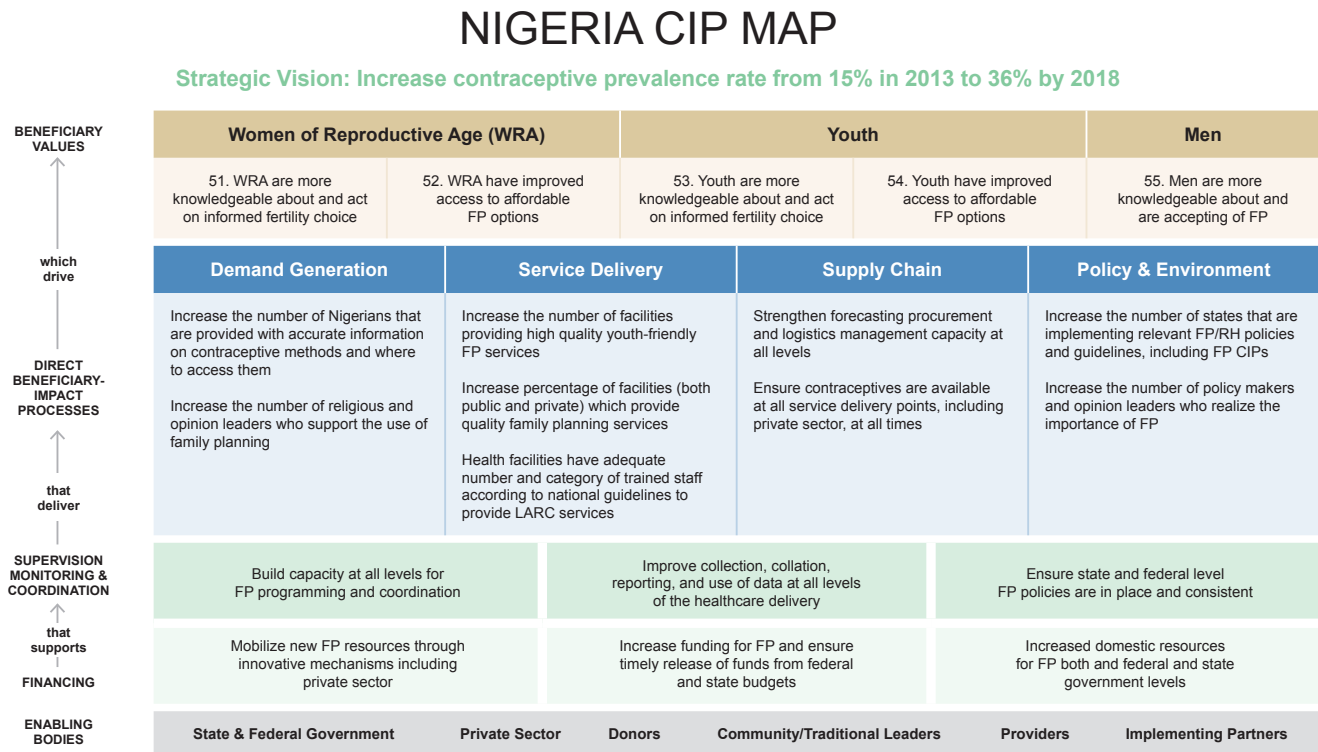
	Political	mCPR impact	Impact on longer term social determinants	Leveraging cost efficiencies	Addressing rights	Addressing equity	Addressing quality
PPFP—immediate postpartum via maternity services	X	X			X	X	X
Reaching unmarried adolescents via school-based curricula			X		X	X	X
Addressing social norms via interpersonal communication		X	X		X	X	

The strategic priorities can either be displayed in a one-page CIP map (see **Appendix 7**) or within the results framework by using colors, symbols, or text to identify them (see **Appendix 6**). They will also be included within the Performance Monitoring Plan (PMP) for the CIP—the *Performance Monitoring Guide* provides detailed guidance on how to develop a PMP for a CIP. Identifying the strategic priorities/key results at this stage allows stakeholder to come to consensus on what must be included in the PMP.

If developing a CIP map, the TST organizes the selected results using the template in **Appendix 7**, and following the sample, **Figure 6**. Starting from the bottom row and moving up, we can see that this map includes the following:

1. Enabling bodies on the bottom row. These are the stakeholders involved in the CIP execution process; they may include government, development, and implementing partners.
2. CIP thematic areas (on the next three rows), categorized into two groups:
  - a. Foundational supportive thematic areas. These are the systems needed for effective CIP execution; they include financing as well as supervision, monitoring, and coordination and are found in the light and dark blue rows of the map.
  - b. Direct beneficiary impact processes. These are broken down into four thematic areas: demand generation, service delivery, supply chain, and policy and environment. Within each area, key results requiring enhanced oversight can be found in the pink bubbles.
3. Beneficiary values, sometimes called beneficiaries, on the red row. These are expected results for populations affected by CIP execution, broken down into three categories: women of reproductive age, youth, and men.
4. The strategic vision at the top. This is the ultimate family planning goal or commitment made by a country and operationalized through the creation of a CIP.

Figure 6: Sample CIP Map



#### d) Select Indicators and Estimate Targets for Outcomes and Outputs

Once stakeholders have developed the results framework, based on agreed-upon interventions, the next step is to assign indicators and estimate targets for the outcomes and outputs. Data collected for indicators provide evidence that a certain result has or has not been achieved. Measurable targets are indicative estimates of the results (outcomes and outputs) to be achieved by implementing specific interventions. Indicators and targets can be qualitative or quantitative, and are used to establish inputs for costing and benchmarks for performance monitoring. In certain cases, some of the performance targets are already set and included in other national strategic documents. The TST should review existing targets and either adopt them or ensure as much alignment as possible with CIP targets.

The TST assigns indicators to the FP goal, outcomes, and key output results. The *Family Planning/Reproductive Health (FP/RH) Indicators Database*, Track20, and PMA2020 provide a comprehensive listing of the most widely used and validated indicators for evaluating FP programs. **Appendix 10** provides illustrative indicators for the results framework example used in this guide. It uses indicators from the FP indicator database. **Box 5** outlines several factors to be considered while assigning indicators, and **Table 4** provides a quick checklist that can be used to review the quality of the indicators in a CIP.

## BOX 5 Considerations for Assigning Indicators

- **Focus on quality, not quantity.** While there is no “correct” number of indicators to assign to the results, indicators should focus on what is critical to inform decision-making, demonstrate achievement of results, and assess implementation gaps.
- **Consider the feasibility of data collection.** Assign indicators that can be realistically collected and monitored given resource and capacity constraints. As such, it is important to also consider data sources when formulating indicators. Depending on the country context, new mechanisms may be needed to collect the new data needed, although it is preferable to use indicators for which data and collection systems already exist.
- **Proxy indicators** can be used as indirect measures of achievement when direct measures are difficult to assign or collect.

**Table 4 | Quick Checklist for Indicators**

Item	Yes	No
Indicators signal how the desired change (for outputs, outcomes, and goals) will be measured.		
Indicators are clearly aligned with the target, using the same unit of measurement.		
Indicators provide critical information needed to support decision-making, demonstrate achievement of results, and assess implementation gaps.		
Indicators are specific, measurable, achievable, realistic, and time-bound (SMART).		
Relevant indicators are disaggregated by sex, age, and/or geographic area.		

Setting targets seamlessly follows identifying indicators. However, quantifying realistic and reliable targets is a complex process, and ideally includes knowledge of baseline values and performance standards to be reached to meet the desired goal. Historical benchmarks established in past program reporting, program evaluations, and studies can be used to estimate the baseline (some of which may have been gathered in Action Step 1 as part of the situational analysis). However, in most cases, baseline values are difficult to get or are out of date, and performance standards are not well articulated. In such circumstances, quantification is typically based on past experience and expert judgment. The goal is to improve accuracy of the target estimate, because guess estimations can lead to over- or under-estimation of costs, and make performance monitoring exercises less meaningful.

For **outcome-level** results, where historical trend data is most available, the team should make attempts to generate performance targets based on past performance, the overall CIP goal that needs to be achieved, and an understanding of the requirements based on the current and desired state analysis. Expert opinion can factor into a decision to enhance or lower the targets based on current contextual factors and whether the desired end state requires moderate or aggressive efforts to be achieved. For example, if historical trends show the teenage pregnancy rates as declining by 0.01 percentage points per year, then this can be used to estimate a decline of 0.05 percentage points in 5 years if all things remain equal. Experts can weigh in on the possibility of further accelerating (or decelerating) this rate based on, for example, expected influx of financial resources, new service delivery channels or products, and/or scaling efforts of interventions.



For **output-level** results—with the exception of estimating commodity requirements (further described below)—the TST can estimate targets for outputs relative to what is required to achieve the desired outcome, while again taking into consideration historical trends, the country context, and the feasibility of achieving the result. Some considerations include likelihood of securing financial resources, infrastructure constraints, and human resources. Further, it is important to have a rational justification that explains the estimate. For example, for the Year 1 target “1,500 maternity providers trained in postpartum IUD (PPIUD),” the justification could be “current project standards are 2 maternity providers trained in PPIUD per facility. Assuming we train staff in 25% of the facilities each year, then we have a target of training 1,500 providers each year.” **Table 5** illustrates this target estimation approach.

**Table 5 | An Example to Illustrate Use of Logical Assumptions to Estimate Targets**

	Year 1	Year 2	Year 3	Year 4
Total number of facilities requiring maternity providers trained in PPIUD	3,000			
% facilities with staff to be trained each year	25%			
<b># maternity providers to be trained/year [standard 2/facility]</b>	1500	1500	1500	1500

If a country is applying the *FP Goals Model*, performance targets for certain outcomes and outputs are generated based on the scale up specified in the selected scenario. For example, a given scenario may indicate a change from 50% to 75% of low-level health centers providing implants, so the output target is that 75% of low-level health centers in the country offer implants. This can be quantified later on during activity planning into the number of providers that must be trained and supervised.

### **Forecast Commodity Requirements**

The CIP includes annual estimates of the quantity of contraceptive commodities needed to meet the FP goal during the period of implementation. Projections for the type and amount of commodities needed—which include the number of women and men to be reached with FP services, as well as the method mix—are based on a number of considerations, including past trends in contraceptive use, contraceptive preferences, budgetary considerations, available registered products, and the capacity to provide a range of methods.

The TST engages stakeholders (specifically, members involved in contraceptive security) to discuss and agree on the assumptions to be used to project the commodity requirements, in consideration of past trends, planned interventions, and the goal CPR. The TST uses the data generated during the situational analysis and FP goal setting (described in previous sections) to generate estimates for the method mix and annual quantities of commodities required. The TST uses tools such as the *CIP Costing Tool*, *Reality* <sup>√</sup>, *CastCost*, and *PipeLine* to forecast commodity requirements. When applying the *FP Goals Model*, the method mix is determined after the TST makes decisions regarding the scale of implementation for specific interventions. The method mix, in turn, is used to calculate commodity requirements.

Upon completion of Action Step 3, the TST and stakeholders will have a complete and validated results framework that reflects strategic priorities, or key results, that are both driving growth and that require enhanced monitoring, as well as indicators and performance targets for outcome and output level results.

## Action Step 3: ACTIVITY PLANNING

### What is Activity Planning?

Once the results framework has been completed and validated, the next step is to develop an implementation plan to describe how outputs (and therefore, outcomes and goals) will be achieved through implementation of specific activities. The implementation plan (see sample in **Appendix 11**) consists of matrices for each thematic area, including the following items for each outcome:

1. Outputs
2. Intervention activities and sub-activities to generate the outputs
3. Target estimates
4. Timeline for implementation

The implementation plan (or activity matrices) forms the basis for costing the plan, where the TST will define inputs of the activities and assign resource estimates.

### How do you Develop an Implementation Plan?

The TST works with the SAGs to develop the implementation plan by performing the following tasks: (1) defining intervention activities, (2) detailing and sequencing sub-activities, and (3) refining and validating the implementation plan.

#### a) Define Activities

The TST works with the SAGs to brainstorm and list activities necessary to achieve the outputs defined under each outcome. Some activities may have already been proposed during the situational analysis stage when problems and solutions were generated, while others may have been discussed during formulation of the results framework when interventions and outputs were generated and prioritized. Both ongoing (those that are already being implemented and deemed essential) and new activities should be considered for inclusion. The TST and stakeholders should incorporate activities that address weaknesses related to rights-based family planning that were identified during the situational analysis. The *FP CIP Themes, Human Rights Elements and Related Actions* tool within the *Rights-sizing Family Planning Toolkit* provides examples of activities that address the rights and empowerment principles organized by traditional CIP thematic areas.

At this stage, the team also checks whether the sum of the proposed activities is sufficient to produce the intended output. If not, they will need to outline additional activities. In some cases, some activities may not lead to the output, so they should be reconsidered. An example list of activities for a specific output is shown in **Appendix 11**.

#### b) Detail and Sequence Sub-Activities

The TST consults with the SAGs to detail the prioritized activities into sub-activities, which are then scheduled to develop the implementation plan. Sub-activities refer to operational tasks involved in executing the activity. This involves defining “how” and “when” the tasks should be implemented, and the frequency of each task (some implementation plans also indicate “who” will implement specific sub-activities). The person adding these details should have knowledge of both the country context

and the implementation processes for the activities. “How-to” guides, such as those available in K4Health Toolkits—such as the *Community-Based Access to Injectables Toolkit*, *the Healthy Timing and Spacing of Pregnancy Toolkit*, *the Postpartum Family Planning Toolkit*, and *the Family Planning and Immunization Integration Toolkit*—are useful resources to assist in this process. Note that, while the approach provided here is a step-by-step process, detailing intervention activities into sub-activities is an iterative process, and each activity can be revised as new information comes to light.

Consider the following when detailing and scheduling sub-activities:

- **Local adaptation:** There is considerable documentation of step-by-step processes on how to carry out different activities, but adaptation to the local context is key and can take time.
- **Capacity:** Knowledge of the capacity available to carry out a specific activity is important, in order to determine how to time and sequence activities. For example, if a location lacks adequate trainers, training for 400 service providers may need to be spread out over three years rather than completed in one year.
- **Efficiencies:** Cost considerations are also important, including whether implementation of sub-activities can be combined to reduce costs. For example, development of a supervision guide and checklist could be combined, instead of separating the two into different activities.
- **Realistic scheduling:** Avoid overloading activities in a given timeframe. For example, it is typical to have a situation where different stakeholder groups working on different technical areas all suggest numerous activities in the first year. When all the activities across different technical areas are combined, the activities can outstrip existing capacity. In such an event, the TST works with the SAGs to realign activities to ensure a realistic spread, in line with available capacity and resources.

### c) Describe the Sub-Activity Targets

The TST consults with the SAGs to define the sub-activity targets that need to be achieved. These targets link directly to sub-activities and form the base units for costing. For example:

- **Activity:** Train providers from labor and delivery in PPF, including PPIUD services
- **Sub-Activity:** Hold 12-day training workshops for labor and delivery providers using PPF curriculum
- **Sub-Activity Level Target:** Workshops held to train 6,000 providers on PPF provision

### d) Refine and Validate the Implementation Plan

After completing the detailing and sequencing process, the SAGs and CIP Task Force should review and validate the entire implementation plan. The TST then incorporates feedback and finalizes the implementation plan before proceeding with costing. Guiding questions to use during the validation exercise include:

- (i) Are the sub-activities complete (that is, none are omitted) to achieve the specified output?
- (ii) Is the outlined process (steps) for implementing each of the specified activities appropriate for the local context?
- (iii) Is the proposed timeline for the sub-activities feasible?
- (iv) Is the appropriate number of activities scheduled for each year?

It is possible that the TST may have gaps regarding sub-activity level targets, which stakeholders can fill in during refinement and validation. Similarly, stakeholders can also make new suggestions for activities or sub-activities during this process. Thus, final validation of the implementation plan may require several iterations of review.

The final implementation plan may look like the sample provided in **Appendix 11**. The format and organization may look differently from one CIP to another, but what is important is for the implementation plan to include the following for each outcome: outputs, intervention activities and sub-activities, target estimates for each output, and a timeline.

At this point, the TST should write up the narrative descriptions of outcomes, outputs, and activities under each thematic area, and put this together with previous text written after the situational analysis, as well as other contents of interest. **Appendix 5** provides a sample table of contents for a CIP.

## Next Steps

Upon completion of the implementation plan, including validation by the SAGs and CIP Task Force, the process continues with Step 5 of the 10-step CIP process, “Estimate Resources and Costs.” Further guidance for costing—including defining inputs and estimating resource requirements—are addressed in other tools in the CIP Resource Kit, namely the [Family Planning CIP Costing Tool](#) and corresponding user guide. As a reminder, the process of moving from activity planning to costing can be iterative. For example, after costing has been done, it is important to review the costs of delivery because significantly high costs may necessitate a review of the prioritized activities to assess feasibility or a realignment of the timing of activities to spread the cost over multiple years. At this point, the TST may want to revisit the estimates and in some cases, they can drop or reduce the scope of activities that are deemed too expensive.

In addition to these steps, the following activities can also be undertaken to bolster CIP resource mobilization efforts:

1. Estimation of the health and development impact of achieving the CIP’s FP goal on health indicators, and the resulting financial savings to the healthcare system. Tools for estimating impact include the following: *Impact 2*, *ImpactNow*, and *OneHealth*. This information can be very useful for advocacy purposes, for example to help convince decision-makers of the merits of resource allocation or to help mobilize additional resources.
2. Identification of financing gaps for each priority area in the CIP. The [Family Planning CIP Gap Analysis Tool](#) and corresponding user guide provide more information on this process.

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## APPENDIX 1

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## APPENDIX 2

# Summary of CIP Development Process in Tanzania with Integration of *FP Goals Model* Application

### *Situational Analysis*

Tanzania began developing its National Family Planning CIP (NFPCIP) 2018-2023 in mid-2017 with a preparatory phase—namely, an end-of-period performance review of the NFPCIP 2010-2015. This review aimed to assess the implementation of the NFPCIP 2010-2015, to examine planned targets vis-à-vis outcomes, and to describe the extent to which these achievements may have contributed to national family planning goals. More specifically, factors were identified that both facilitated and hindered progress toward achieving outcomes, actionable recommendations were identified, and considerations were generated to inform the development of NFPCIP 2018-2023. Results from this assessment were shared at a stakeholders meeting in Dar es Salaam in May 2017 and provided important background for developing the NFPCIP 2018-2023.

In June 2017, data on key family planning indicators, gleaned from the national health information management system, were shared with stakeholders at the annual data consensus meeting organized by the Ministry of Health—Community Development, Gender, Elderly and Children (MOHCDGEC). These data, along with data from other key resources such as the Demographic and Health Survey (2016), the UNFPA facility survey (2016), and partner reports, coupled with the results of the end-of-period performance review, served as the foundation for the NFPCIP 2018-2023 situational analysis.

In July 2017, a Technical Support Team (TST) was established to coordinate the development of the NFPCIP 2018-2023. This small team, headed by the FP Unit of the Reproductive Child Health Sector (RCHS) of the MOHCDGEC, and with participation from key technical assistance partners, proposed a process for developing the NFPCIP 2018-2023 which was validated by the National FP Technical Working Group (NFPTWG). Under the direction of the RCHS, strategic advisory groups (SAGs) were established for each of the following thematic areas, which were also validated by the NFPTWG: demand creation, service delivery, contraceptive security, and enabling environment. The service delivery thematic area was further subdivided into facility, community, and private. Each SAG was co-chaired by an MOHCDGEC representative and an implementing partner representative and was made up of experts from the MOHCDGEC, development partners, and implementing partners who provided critical input throughout the NFPCIP 2018-2023 development process.

### *Results Formulation*

The TST guided the SAGs through a series of technical consultations that included reviewing the situational analysis and baseline data and conducting a root cause analysis for bottlenecks, as well as articulating an initial set of high-level intended results. These high-level results were applied to the *FP Goals Model*, a strategic planning tool that estimates the impact of multiple family planning interventions on mCPR based on a country's context and global evidence on intervention effectiveness.

The *FP Goals Model* identified three broad intervention areas as having the potential to drive national mCPR growth if implemented at scale: increasing use of postpartum family planning,

addressing social norms that hinder FP uptake, and reducing stock-outs of contraceptives. The model analyzed regional data and thereby indicated which interventions should be implemented in which regions to reach the national mCPR goal of 45% by 2023. The model also presented data suggesting which interventions have likely led to recent gains in mCPR and should, therefore, be maintained during the CIP period. Application of the *FP Goals Model* was a first step in prioritizing high-level intervention areas—a process that continued throughout the rest of the development of NFPCIP 2018-2023.

Validation meetings, at both the national and regional level, were held in August and September 2017 to agree on the broad intervention areas that the *FP Goals Model* highlighted and to solicit feedback on whether additional strategic priorities should be added. During regional meetings, district-based stakeholders provided input into the feasibility of implementing activities within the broad intervention areas, including specific challenges that they anticipate facing. All stakeholders agreed upon the three broad intervention areas, with a nearly universal recommendation to also include reaching youth and adolescents with information and services as an important, cross-cutting priority. A targeted meeting with key officials responsible for health program implementation at the President's Office Regional Administration and Local Government Authority (PO-RALG) was also held to gather input on implementation modalities at council and community level.

### *Activity Planning*

After validation of the high-level intervention areas, the SAGs met multiple times from October to December to finalize the results framework and to plan activities to be implemented within each thematic area, aligned to the strategic priorities that had been agreed upon. The activity matrices, including detailed sub-activities, inputs, and a timeline for implementation, were finalized through a series of group and one-on-one consultations with key partners, with oversight by RCHS. Activities and sub-activities were costed using unit costs collected from the Tanzania context. Concurrently, key indicators were prioritized for performance monitoring over the NFPCIP 2018-2023 implementation period. Finally, the RCHS circulated multiple draft versions of the NFPCIP 2018-2023 to key stakeholders and partners before it was finalized.



## APPENDIX 3

# Situational Analysis: Guiding Questions and Topics for Information Gathering

Guiding Questions/Topics	Information Source	Tools/Frameworks
<b>Context Analysis</b>		
<p><b>Political and Policy Environment</b></p> <ul style="list-style-type: none"> <li>• Do most FP program stakeholders believe that they have the unequivocal support of the highest levels of government to carry out their activities?</li> <li>• Are FP program stakeholders confident that they are receiving all possible support from government leaders?</li> <li>• Have political and program leaders succeeded in mobilizing the maximum amount of resources available from both national and international sources?</li> <li>• Has the country articulated a national strategic plan or national population policy that has been endorsed by the offices of the president, cabinet, and parliament? If so, has it received funding to match the scope of the proposed activities?</li> <li>• Do senior political leaders speak out effectively and often about FP and/or the impact of FP?</li> <li>• Is there a supporting set of laws and regulations (for example, legal age of marriage, legal status of specific contraceptive methods) designed to make FP policies and programs function as effectively as possible?</li> <li>• In what ways is FP featured in different health and non-health policies?</li> <li>• To what extent are FP-related policies implemented?</li> <li>• To what extent does the budgeting process facilitate or hinder implementation of a sound program?</li> <li>• What operational barriers exist in implementation of FP-related policies?</li> <li>• To what extent do existing policies respect/ protect/fulfill rights to accessing FP? Are there unnecessary barriers to access?</li> <li>• To what extent do policies ensure contraceptive security, including access to a range of methods and service modalities—public, private, and nongovernmental?</li> </ul> <p><i>The recommended policy checklist tool (listed in the right column) provides a list of questions to guide the policy analysis.</i></p>	<ul style="list-style-type: none"> <li>• Policy documents</li> <li>• Budget cycle</li> <li>• Expert consultations</li> </ul>	<p><i>Policy Checklist: Essential Elements for Successful FP Policies (HPP)</i></p> <p><i>Rights-sizing Family Planning Toolkit</i></p>
<p><b>Economic Environment</b></p> <ul style="list-style-type: none"> <li>• What are the trends in government financing of the FP program?</li> <li>• What is a reasonable expectation regarding governmental financing of the FP program?</li> <li>• To what extent can the country tap into local financing opportunities? How realistic is this?</li> <li>• What are some unusual or innovative financing mechanisms that have been used in other sectors? Could they be applied to FP?</li> <li>• To what extent are economic factors driving fertility preferences of the community? Which communities are most affected?</li> </ul>	<ul style="list-style-type: none"> <li>• Policies</li> <li>• Program documents</li> <li>• Expert consultation</li> </ul>	<p><i>FP Financing Roadmap</i></p>

## APPENDIX 3 (continued)

Guiding Questions/Topics	Information Source	Tools/Frameworks
<p><b>Social Environment</b></p> <ul style="list-style-type: none"> <li>• How do gender norms and inequalities influence women's access to and use of FP?</li> <li>• How do laws, regulations, policies, religious and cultural traditions, and other factors influencing gender norms affect women's status, equality, and reproductive rights?</li> <li>• What are the social, economic, and political factors that shape the lives of women/girls and men/boys in this setting? How do these gender inequalities affect FP?</li> <li>• What is the extent of the government's political commitment to supporting FP programs that respect, protect, and fulfill rights (especially in the areas of information, supplies, and services)?</li> <li>• To what extent does the program consider the attainment of high quality of care (quality, accessibility, availability, and acceptability)?</li> <li>• To what extent are the political, financial, and social environments supported by the effective participation of diverse community groups (especially youth) in all aspects of FP policy and program development, implementation, and monitoring?</li> </ul>	<ul style="list-style-type: none"> <li>• Legislative documents</li> <li>• Policies</li> <li>• Regulations</li> <li>• Program documents</li> <li>• Expert consultations</li> </ul>	<p><i>Rights-sizing Family Planning Toolkit</i></p> <p><i>A Practical Guide for Managing and Conducting Gender Assessments in the Health Sector</i></p> <p><i>Voluntary Family Planning Programs: A Conceptual Framework</i></p>
<b>Beneficiary Profile Analysis</b>		
<p><b>Beneficiary Profile</b></p> <ul style="list-style-type: none"> <li>• What is the size of the total beneficiary population (for example, the number of women of reproductive age—15-49 years)?</li> <li>• What is the annual rate of population growth?</li> <li>• What age group constitutes the largest segment of the reproductive population?</li> <li>• What is the size of the beneficiary population that demand FP?</li> <li>• How many sexually active women of reproductive age are using modern contraceptive methods?</li> <li>• What is the percentage distribution of contraceptive users by FP method?</li> <li>• What is the percentage of FP service users who report using a public sector source? A private sector source?</li> <li>• What is/are the demographic profile(s) of women with an unmet need for contraception (considering education, residence, age, economic status)?</li> </ul>	<ul style="list-style-type: none"> <li>• National census data</li> <li>• Demographic and Health Surveys</li> <li>• Household surveys</li> <li>• MICS</li> <li>• PMA2020 research reports</li> </ul>	
<p><b>Trends in Population Growth and Contraceptive Use</b></p> <ul style="list-style-type: none"> <li>• What is the division of population by geographical location (rural vs. urban)?</li> <li>• What is the annual change in CPR (by age, geographical area, education, wealth quintile)?</li> <li>• What are the method mix trends?</li> <li>• What is the average annual change in use for each method?</li> <li>• Which methods are increasingly being used and which ones are not?</li> <li>• How has demand for FP and desired family size changed?</li> </ul>	<ul style="list-style-type: none"> <li>• National census data</li> <li>• Demographic and Health Surveys</li> <li>• Household surveys</li> </ul>	

Guiding Questions/Topics	Information Source	Tools/Frameworks
<b>Current/Desired State Analysis</b>		
<ul style="list-style-type: none"> <li>• What is the current state of FP, described by key metrics?</li> <li>• What is the key FP goal(s) the country is trying to achieve, described by key metrics?</li> <li>• What is the required growth per year for the country to achieve its goal(s)?</li> <li>• What are historical rates of growth per year for the stated goal(s)?</li> <li>• To what extent is the required growth rate realistic given historical trends?</li> <li>• What are the key considerations for the program to meet the required growth rate during the period of the plan?</li> </ul>	<ul style="list-style-type: none"> <li>• Demographic and Health Surveys</li> <li>• Programmatic documents</li> <li>• Policy documents</li> <li>• Research publications</li> <li>• Stakeholder analysis</li> </ul>	
<b>Program Performance Analysis</b>		
<p><b>Supply</b></p> <p><b>Contraceptive Security</b></p> <ul style="list-style-type: none"> <li>• What are the key issues that need to be addressed, and opportunities that need to be leveraged to facilitate a contraceptive security?</li> </ul> <p><b>Service Delivery</b></p> <ul style="list-style-type: none"> <li>• What are the key issues facing <i>each</i> of the different service modalities for FP services, preventing them to function effectively? Service modalities include facility-based, community, outreach, pharmacies/drug shops in public and private sector. Note: sometimes private and public sector platforms have a different spectrum issues and hence should be assessed differently.</li> </ul> <p><b>Key Issues to assess:</b></p> <ul style="list-style-type: none"> <li>• Availability of equipment, staff, and tools</li> <li>• Infrastructure</li> <li>• Provider skills and attitudes</li> <li>• Supervision</li> <li>• Existence of operational policy barriers</li> <li>• Functioning of QA/QI systems</li> <li>• Accountability measures that ensure that women’s needs and desires are being met</li> <li>• Broad method mix offered</li> <li>• Extent of youth-friendly services offered</li> <li>• User fees</li> <li>• Counseling and client assessment</li> <li>• Functioning of integration of services</li> </ul>	<ul style="list-style-type: none"> <li>• Service Provision Assessments</li> <li>• Contraceptive Security Assessments</li> <li>• Program, Survey and Research Reports</li> <li>• Expert Consultations</li> </ul>	<p>Contraceptive Security:</p> <p><i>Strategic Pathway to Reproductive Health Commodity Security (SPARCHS)</i></p> <p><i>RHCSAT: Reproductive Health Commodity Security Situational Analysis Tool</i></p> <p>Private sector:</p> <p><i>Assessment to Action</i></p>

(continued)

## APPENDIX 3 (continued)

Guiding Questions/Topics	Information Source	Tools/Frameworks
<p><b>Demand</b></p> <ul style="list-style-type: none"> <li>• Is there a strategy for social and behavior change communication (SBCC) in place? If yes, to what extent has the strategy been effectively implemented? What challenges experienced have you experienced?</li> <li>• To what extent are a variety of media channels used to execute the SBCC strategy?</li> <li>• To what extent are provider materials (for information, education, and counseling) adequate, up-to-date, and effective?</li> <li>• To what extent do the SBCC activities include interventions to affect positive social and gender norms?</li> <li>• To what extent do the SBCC activities incorporate new technology, such as ICT and other digital strategies?</li> <li>• To what extent do the SBCC activities engage champions, including religious leaders?</li> <li>• To what extent do the SBCC activities include commercial and social marketing approaches for promotion?</li> <li>• To what extent does the SBCC strategy recognize different segments of the beneficiary population, and respond to their different needs?</li> <li>• To what extent do the SBCC activities include advocacy interventions to gain general public support for FP?</li> </ul>	<ul style="list-style-type: none"> <li>• Program Documents and Reports</li> <li>• Expert Consultations</li> </ul>	<p><i>SEED Model</i></p>
<p><b>Enabling Environment</b></p> <p>(Focus on program-level)</p> <ul style="list-style-type: none"> <li>• To what extent are resources (financial, human, technology, etc.) made available, allocated, and spent effectively and equitably to facilitate achievement of country FP goals?</li> <li>• To what extent are new financing mechanisms for FP (including health insurance, results-based financing) identified and tested?</li> <li>• To what extent is FP acknowledged as a development intervention, beyond health?</li> <li>• To what extent is the country program addressing social determinants that pre-disposes the population to risks of unintended pregnancies and contraceptive non-use?</li> <li>• To what extent is the country thinking comprehensively about a rights-based approach when serving their population?</li> <li>• To what extent is the FP program well-coordinated, at various levels, to improve effectiveness and efficiency of the program?</li> <li>• Do Ministry of Health staff have the requisite skills and resources to effectively run the FP program?</li> <li>• What barriers are there in executing existing policies?</li> </ul>	<ul style="list-style-type: none"> <li>• Program documents and reports</li> <li>• Expert consultations</li> </ul>	<p><i>SEED Model</i></p>

## APPENDIX 4

## Example of an Issue-Solution Matrix

## FP CIP Key Issues and Proposed Solutions

Last updated: \_\_\_\_\_

#	Item	TECHNICAL AREAS		
		Issue / Solution	Technical Area	Sub-Area
1	Policies restrict CHWs to provide injectables	I	PE	Service delivery
2	Commodities are stuck at central medical stores and are not well distributed to facilities	I	CS	Distribution
3	Health facilities face challenges placing orders for commodities	I	CS	Quantification & forecasting
4	The method mix is not broad (for example, emergency contraceptives are not procured for the public sector)	I	CS	Method mix
5	Institute real-time stock monitoring system	S	CS	Quantification & forecasting
6	Districts do not allocate resources for FP	I	FC	Resource mobilization
7	Engage private sector, demonstrate return on investment for FP	S	FC	Private sector
8	Ministry of Education policies restructuring sexual education in schools	I	PE	Youth
9	CHWs' approach is scarce, only in few areas, and not sustainable	I	SD	Community-based
10	Service statistics are unavailable and unreliable	I	LM	Health management information system
11	Staff are overburdened and have low motivation	I	SD	Human resources
12	Outdated guidelines for provision of long-acting methods	I	SD	Human resources
13	Establish youth corners for FP information	S	SD	Youth
14	There are many myths and misconceptions around FP	I	DC	Social and behavior change communication (SBCC)
15	Address male involvement through SBCC	S	DC	SBCC

## ISSUE/SOLUTION

I - Issue

S - Solution

## TECHNICAL AREAS

DC - Demand creation

SD - Service delivery and access

CS - Contraceptive security

PE - Policy and enabling environment

FC - Financing

LM - Leadership, management, and stewardship

## APPENDIX 5

# Conducting a Root-Cause Analysis

A root-cause analysis is a systematic approach to examining an issue to identify the root cause and associated linkages. Simply stated, a root-cause analysis helps identify what, how, and why something happened, thus helping to develop a comprehensive solution to the problem. The better the problem is understood, the better a solution can be designed to address it. Below are two common approaches that can be used to perform a root-cause analysis.

### (i) The “Five Whys” Approach

“Five Whys” is an iterative question-asking technique used to explore the cause-and-effect relationships underlying a particular problem. The TST works with stakeholders grouped around technical areas to go through a series of five “why” questions to identify the root cause of the main issue that can be directly addressed by an intervention activity. The example below (**Appendix Table 1**) is used to illustrate this task using high rates of teenage pregnancy as the key issue. A few things to consider while performing this task:

- A rule of thumb is to go through a series of up to five “whys.” As you can see below, the first and second “why” yield “causes” that require multi-pronged interventions, while the third “why” yields discrete issues that can be addressed by a single intervention (for example, “update adolescent guidelines and policies”).
- A considerable amount of information is already gathered in the issues-solutions matrix to perform this analysis. However, new causes (marked with \*\* below) that were previously not elicited in consultations, may arise. This is expected, as this task analyzes the issues in detail.
- Branches of questions may be formed as a result of responses to previous questions.

### Appendix Table 1 | Example of a Root-Cause Analysis of Key Issue

Identify the key issue under each sub-area. *Note:* There can be more than one key issue, but each one should undergo a separate root-cause analysis.

**Key issue:** High rates of teenage pregnancy

(1) *Ask: Why are there high rates of teenage pregnancy?*

- Low utilization of FP services among young people

(2) *Ask: Why are young people not using FP methods?*

- Young people lack knowledge on how to prevent unintended pregnancies
- Community-based programs are not youth-friendly
- Coverage of the youth-friendly service approach is low, hence young people find it difficult to access services

(3a) *Ask: Why are young people lacking knowledge on how to prevent pregnancy?*

- Behavior change campaigns are not targeting young people\*\*
- Ministry of Education policies are not favorable towards FP education in schools

(3b) *Ask: Why are facility and community-based services not youth-friendly?*

- Adolescent guidelines and policies are outdated\*\*
- Providers in facilities respond negatively to young people who seek FP services\*\*

## (ii) Problem Tree Analysis

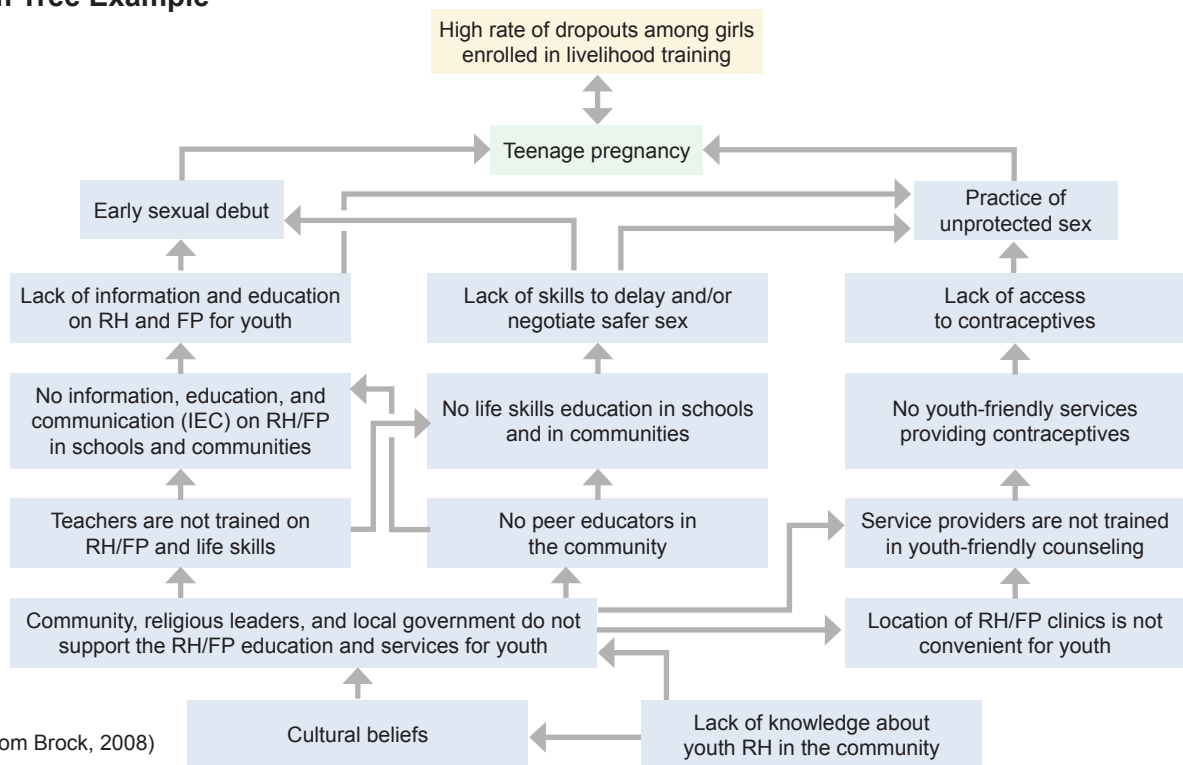
A problem tree analysis helps to map out the anatomy of cause and effect around an issue. This method is best conducted in a small group of about six to eight people, with a flip chart or post-it notes on a wall.

The TST works with stakeholders grouped around technical areas to use the information from the situational analysis (specifically from the issue/solution matrix) to generate a problem tree. See below for: (1) steps to generate a problem tree, and (2) a sample problem tree. The heart of this exercise is the discussion, debate, and dialogue generated as factors are arranged and re-arranged. It is essential to take time to allow people to explain their thoughts and reasoning, and to record related ideas and points that come up (on separate flip chart sheets, under titles such as solutions, concerns, and decisions).

### Steps to a Problem Tree Analysis:

1. Review and discuss the issue/solution list generated as part of gathering and synthesizing information in Action Step 1 and agree on the key issue or problem to be analyzed. This becomes the “focal problem.” (For example, the key issue could be high rates of teenage pregnancy.)
2. Identify the causes of the focal problem (these become the “roots”) and the consequences (which become the “branches”). These causes and consequences can be written down on post-it notes or cards, either individually or in pairs, and then arranged according to cause-and-effect logic.
3. Sort all other problems in the same way, with the guiding question being: “What causes that?”
4. Review the diagram and verify its validity and completeness. Discussion questions might include:
  - Are each of the causes and effects logical?
  - Are there important problems that have not been mentioned yet? If so, specify which problems and include them at an appropriate place in the diagram.
  - Does this represent the total reality of the issue? Are there economic, political and socio-cultural dimensions to consider?

### Problem Tree Example

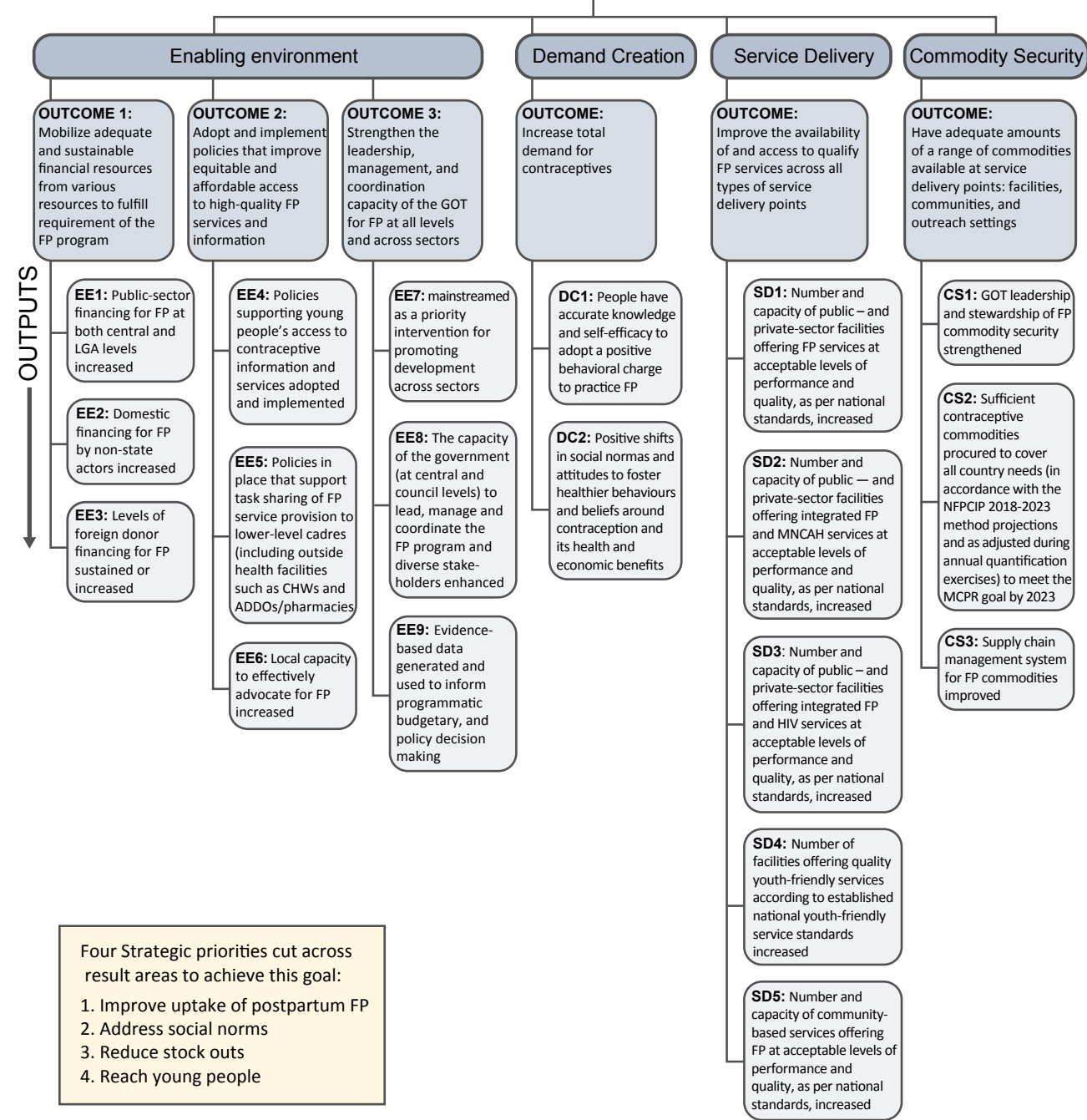


(adapted from Brock, 2008)

## APPENDIX 6

# Results Framework from Tanzania National Family Planning CIP 2018-2023

**Goal:** As a result of implementing strategic priorities, mCPR among all women will increase from 30% in 2018 to 40% in 2023

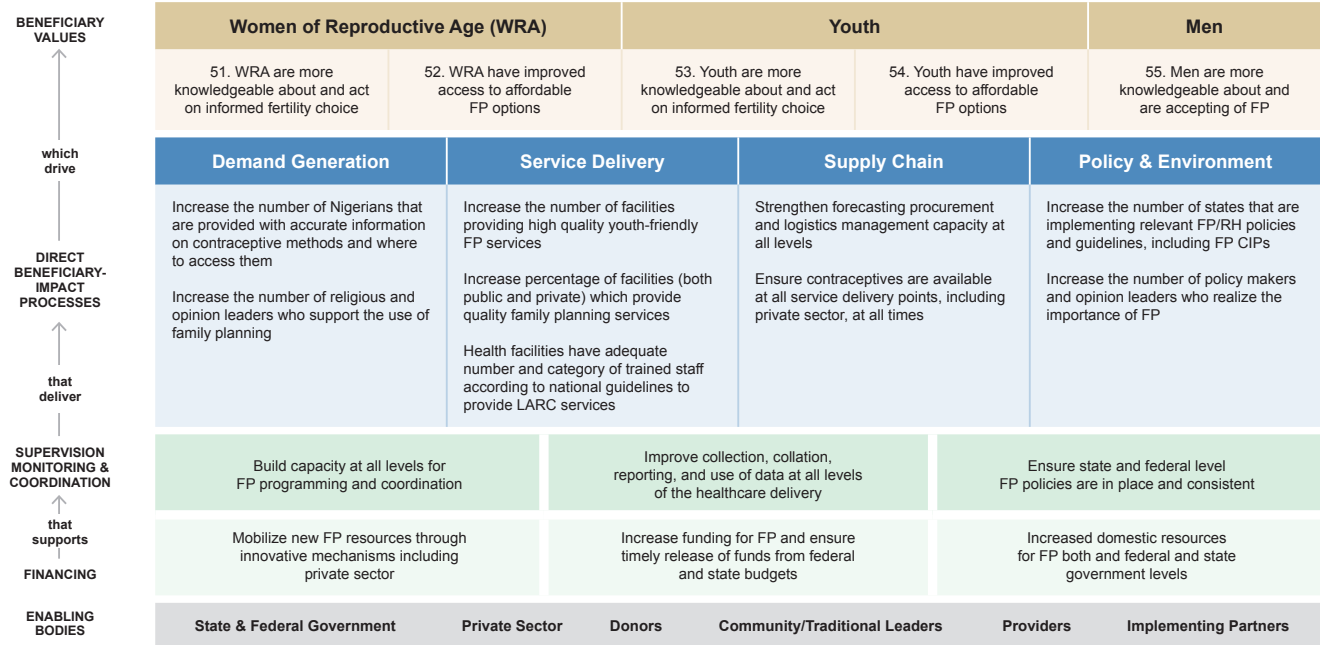




## APPENDIX 7

# Nigeria CIP Map

**Strategic Vision: Increase contraceptive prevalence rate from 15% in 2013 to 36% by 2018**



## APPENDIX 8

# Metrics for FP Goals

The table below provides pros and cons for using different types of metrics while defining or refining a country's FP goal. This table is based on a literature review on this subject, included in the references section, and listed below:

- Cates W, Stanback J, Maggwa B. Global FP metrics – time for new definitions? *Contraception*. 2014; 90 (5); 472-475. Available from: <http://dx.doi.org/10.1016/j.contraception.2014.06.037>
- Fabic M, Choi Y, Bongaarts J, Darroch JE, Ross JA, Stover J, Tsui AO, Upadhyay J, Starbird E. Meeting demand for family planning within a generation: The post-2015 agenda. *The Lancet* 2014; DOI: 10.1016/S0140-6736(14)61055-2.

**Appendix Table 2 | Metrics for FP Goals**

Metric	Pros	Cons
<b>Modern contraceptive prevalence rate</b>	<ul style="list-style-type: none"> <li>• Simple, direct population-based measure of FP use.</li> <li>• Can also be applied to sub-groups, such as urban/rural, youth, or vulnerable populations.</li> </ul>	<ul style="list-style-type: none"> <li>• Does not reflect the relative contraceptive effectiveness of the methods, as many methods of varying effectiveness are lumped into the term “modern methods of contraception”</li> </ul>
<b>Unmet need for contraception</b>	<ul style="list-style-type: none"> <li>• A measure of potential demand, focusing on the magnitude of need among those who are obvious targets of interventions.</li> <li>• A useful measure for advocacy, and can be tracked over time.</li> <li>• Unmet need can also be disaggregated by the reproductive intention to space or to limit—as such, it helps program experts focus on reproductive intentions.</li> </ul>	<ul style="list-style-type: none"> <li>• It is a mixed indicator: Typically, unmet need starts off low (because demand for FP is low), then rises (as demand increases and a country's FP programs are unable to keep up with the rising demand), and eventually falls (when programs/supply start to meet demand).</li> </ul>
<b>Couple of years of protection (CYP)</b>	<ul style="list-style-type: none"> <li>• Economical, as no population-based surveys are necessary. This is a simple measure of contraceptive use/uptake based solely on service statistics.</li> </ul>	<ul style="list-style-type: none"> <li>• CYPs from long-acting reversible contraception are attributed to the year in which they were provided. This tends to inflate the CYPs for that particular year, and their contribution to future CYPs is not accounted for in subsequent years. This could lead to unreliable projections of commodity requirements.</li> </ul>
<b>Percent demand for FP satisfied with modern methods</b>	<ul style="list-style-type: none"> <li>• Measure of success among the relevant population—those with need/demand for FP—rather than the total population.</li> </ul>	<ul style="list-style-type: none"> <li>• Unable to differentiate between programs that provide a full range of methods (including highly effective methods) and those that rely primarily on less effective, short-acting methods.</li> </ul>

## APPENDIX 9

# Prioritization Matrix

A prioritization matrix tool can help stakeholders make decisions by narrowing intervention options down by systematically comparing choices through the selection and application of criteria. Because the process relies primarily on expert judgment, it can be subjective. As such, in order to produce more objective assessments during the rating process, it is important to ensure the participation of a wide variety of stakeholders, work in diverse teams, and encourage discussion.

Use of the four-quadrant prioritization matrix involves the following actions:

### (i) Define the Criteria for Prioritization

The TST (in consultation with the CIP taskforce) defines the criteria to be used. The following two criteria can be used: impact and feasibility.

- *Impact* refers to the relative contribution of the desired outcome/output to the goal (for example, mCPR). Assessment of impact should consider the existence of evidence supporting the effectiveness of the intervention. Stakeholders may also reflect on the total number of potential beneficiaries and the potential time required to implement a given intervention.
- *Feasibility* refers to the ease of implementation and maintenance, and the extent to which the proposed output can be achieved at scale within the existing time and budgetary constraints. Issues of cost of delivery, capacity, policy contexts, cost-effectiveness, and sustainability are considered here. Contextual factors generated during the situational analysis are used here. Also, this criterion takes into consideration whether FP stakeholders have direct or indirect control over achievement of the outputs. For example, achieving an output of “new health providers recruited” may not be in the purview of the FP division of the MOH, and hence may receive a lower feasibility score. Careful consideration of environmental, social, economic, and political issues will help to rule out results that cannot be achieved in the near future.

### (ii) Assign Scores to the Outputs/Interventions

In thematic area groups, SAGs can use the questions in **Appendix Table 3** to collectively discuss and assign a score according to the two criteria (impact and feasibility). To simplify the process, the score ranges from 0 to 5, with 5 being the high feasibility or impact. The SAG enters the scores into a prioritization matrix (see **Appendix Table 4**).

### Appendix Table 3 | Illustrative Questions for Prioritization Discussions

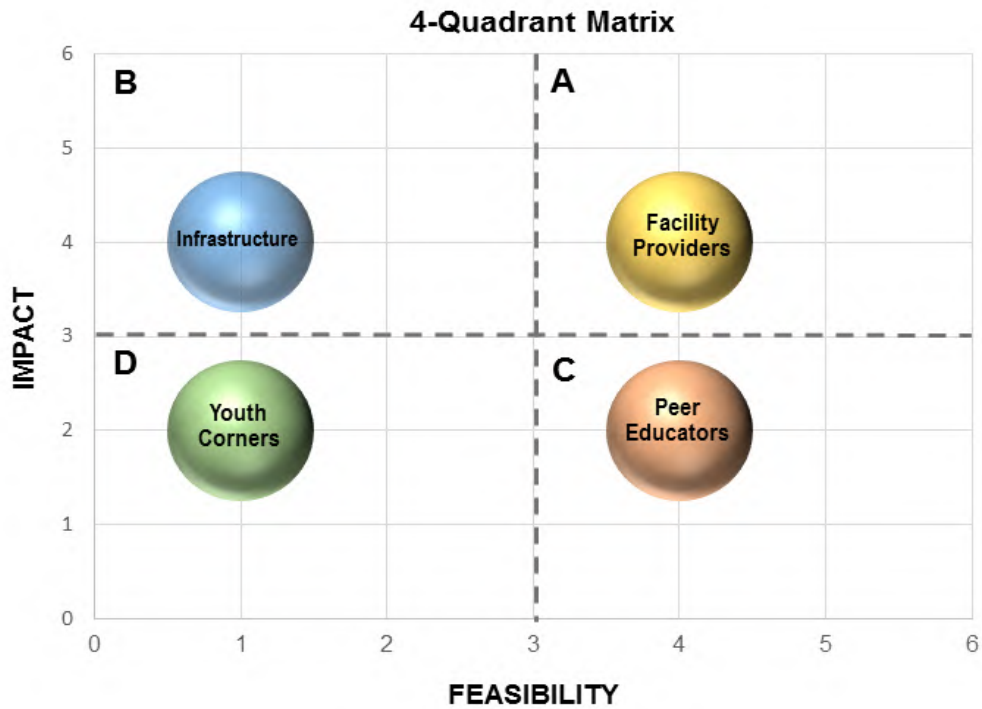
<b>Impact</b>	<ul style="list-style-type: none"> <li>• Based on sound evidence of its effectiveness, is this output likely to bring about the desired change at scale?</li> <li>• What are the relative risks associated with exacerbation of the problem, if not addressed?</li> </ul>
<b>Feasibility</b>	<ul style="list-style-type: none"> <li>• What is the relative ease of implementation of the activities to implement the proposed result?</li> <li>• Is there technical, financial, and human capacity to implement the actions?</li> <li>• Is the cost of delivery realistic?</li> <li>• Do the FP stakeholders have direct influence over the attainment of the result, or does it require input from others?</li> <li>• Is this result likely to be sustainable in the long term?</li> <li>• What are the assumptions or prerequisites to achieving these results (for example, policy change)?</li> <li>• Can this be output be achieved during the CIP period?</li> <li>• Are there any legal, policy, or ethical concerns that may arise during implementation of activities to attain this result?</li> </ul>

### Appendix Table 4 | Illustrative Prioritization Matrix

Outputs	Impact Score	Feasibility Score	Quadrant	Priority Level
Youth corners established outside health facilities to serve as FP information hubs	2	1	D	Low
Facility-based providers trained in the provision of youth-friendly services, including addressing barriers to provision of services to youth	4	4	A	High
Peer educators recruited, trained, and supported to provide FP information among their peers	2	4	C	Medium
Infrastructure for youth-friendly services established at dispensary, health centers, and district levels, including facilities in higher learning institutions	4	1	B	Medium

#### (iii) Map Out Results into Four Quadrants

After the scoring exercise, the TST maps the results into the four-quadrant grid, according to their scores for feasibility and impact. Viewing the interventions in the grid will allow stakeholders to have a better idea of how they compare to one another. Alternatively, the quadrant assignment can be added directly to the prioritization matrix (**Appendix Table 4**). Each quadrant assignment has an interpretation, as described in **Appendix Table 5**.



Appendix Table 5 | Implications for Action, by Priority Level

Quadrant	Priority Level	Description	Implications
A	High	<b>High Impact/High Feasibility:</b> With high feasibility and high impact, these are the highest priority results and should be given sufficient resources to maintain and continuously improve.	<ul style="list-style-type: none"> <li>Assign high target estimates for costing because these should be implemented in high numbers.</li> </ul>
B	Medium	<b>High Impact/Low Feasibility:</b> These are long-term results that have a great deal of potential, but will require significant investment and time to implement. Focusing on too many of these can overwhelm the program.	<ul style="list-style-type: none"> <li>Further explore the assumptions and risks associated with achieving these results (they are likely to be high, and additional interventions may need to be included in the activities to minimize the risk). For example, the intervention “<i>Hire new service providers</i>” may have a low feasibility rank and may carry the risk of not being implemented, unless other activities are also added (such as advocacy to the government to add more staff).</li> <li>Phase target estimates over a longer time, as change may not be expected in the near term.</li> </ul>
C	Medium	<b>Low Impact/High Feasibility:</b> Often politically important and difficult to eliminate, these items may need to be re-designed to reduce investment while maintaining impact.	<ul style="list-style-type: none"> <li>Explore how best to increase impact or discuss alternative approaches.</li> <li>Assign low-medium target estimates for costing.</li> <li>Integrate with other results, if possible.</li> </ul>
D	Low	<b>Low Impact/Low Feasibility:</b> With minimal impact, these are the lowest priority outputs and should either be phased out or reconsidered with revision, allowing for resources to be reallocated to higher priority items.	<ul style="list-style-type: none"> <li>Consider dropping from list.</li> <li>If keeping it on the list, carefully examine the potential value added to include in the plan, and consider having low costing targets.</li> </ul>

## APPENDIX 10

## Sample Indicators for Results Framework

Results	Indicators	Data Source
<p><b>Goal</b></p> <p>Increase contraceptive prevalence from 26% in 2012 to 50% by 2017</p>	Modern CPR	DHS, PMA2020
<p><b>Outcomes</b></p> <p>Reduced teenage pregnancies</p>	Adolescent birth rate	DHS
Increased access to contraception among young people	<u>Contraceptive prevalence rate among young people</u>	DHS
Young people (10-24 years of age) are knowledgeable about FP	<u>Percent of the population who know of at least one source of modern contraceptive services and/or supplies (disaggregated by age)</u>	DHS
Coverage of youth-friendly services at facility and community levels is increased	<u>Percent of service delivery points providing youth-friendly services</u>	Facility records
<p><b>Outputs</b></p> <p>A communication strategy to ensure honest, accurate, clear, and consistent FP messaging that targets young people is developed and implemented</p>	<p>Existence of a communication strategy targeting young people</p> <p><u>Number/percentage of adolescents served or reached by the program</u></p>	Program reports
Ministry of education policies revised to allow the school health curriculum to include messages on SRH, including prevention of teenage pregnancy	<u>Existence of supportive adolescent and youth SRH policies</u>	Content analysis of policies
Updated adolescent SRH guidelines and policies	<u>Existence of supportive adolescent and youth SRH policies</u>	Content analysis of policies
Providers sensitized and trained on youth-friendly services	<u>Number/percentage of health workers trained to provide adolescent and youth-friendly services</u>	Program reports
Peer educators recruited, trained, and supported to provide FP information among their youth peers	<u>Number of young people trained as peer educators</u>	Program reports
Youth corners outside health facilities are established to serve as FP information hubs	Number of youth corners established	Program reports

## APPENDIX 11

## Sample Implementation Plan

## Technical Area: SERVICE DELIVERY AND ACCESS

Intermediate Outcome: Reduced rates of teenage pregnancy

Indicator: Adolescent birth rate

Outputs	Intervention Activities	Sub-Activities	YR1	YR2	YR3	YR4	YR5	Indicator
<b>1) Coverage of youth-friendly services (YFS) at facility and community levels is increased</b>								
<b>Immediate Outcomes</b>								
• 1a) 507 providers sensitized and trained on YFS	1ai) Update and disseminate 3,000 copies of the adolescent guidelines and policies	Review/revise guidelines	X					Number/ percentage of health workers trained to provide adolescent and YFS Number of trainers oriented to YFS and peer education
		Formalize and disseminate guidelines at central and district levels	X					
	1aii) Update 25 FP trainers on the key strategies for YFS and peer education	Train trainers on YFS		X				
	1aiii) Train 507 facility-based providers in the provision of YFS, including addressing barriers to provision of services to youth	Engage a consultant to revise/ update the YFS training manual for service providers	X					
		Convene two technical consultation meetings to review and endorse revised training manual	X					
		Print 200 copies of the YFS training manual	X					
		Organize 20 three-day training sessions for 400 service providers (each session = 20 people)		X	X	X		
• 1b) 1,125 peer educators recruited, trained, and supported to provide FP information among their peers	Recruit and orient 1,125 peer educators in promoting use of FP by youth in communities	Convene workshops to review and update existing national peer training tools and materials	X					Number of young people trained as peer educators
		Hold regional youth camps to recruit and orient peer educators		X				
		Supervise youth plans that are developed		X	X			
		Convene workshops to review and update existing national peer training tools and materials		X				

## APPENDIX 11 (continued)

Outputs	Intervention Activities	Sub-Activities	YR1	YR2	YR3	YR4	YR5	Indicator
• 1c) 141 youth corners established outside health facilities to serve as information hubs on FP	Establish infrastructure for 656 youth-friendly services at dispensary, health centers, and district hospitals levels, including facilities in higher learning institutions	Map current clinics without youth corners		X				Percent service delivery points providing youth-friendly services
		Identify space in centers currently without clinics and furnish		X				
<b>2) Young people (10-24 years of age) are knowledgeable about FP</b>								
<b>Immediate Outcomes</b>								
2a) A communication strategy to ensure honest, accurate, clear, and consistent FP messaging that targets young people is developed and implemented	Meeting to determine TOR for the consultant who will develop the communication strategy	Meeting to determine TOR for the consultant who will develop the communication strategy	X					Existence of a communication strategy targeting young people
		Engage a research consultant to help understand why the current messaging is not resonating with certain groups of people	X					Number/percentage of adolescents served or reached by the program
		Disseminate research findings	X					
	Create a yearly youth magazine that describes youth FP activities to occur throughout the year	Write and disseminate youth magazine	X	X	X	X	X	
	Produce youth FP pull-outs to put in newspapers	Write youth FP pull-out document for newspapers	X	X	X	X	X	
	Create a BlogSpot as a reference point for further feedback from youth	Develop youth blog spot hosted by youth to answer common FP questions	X	X	X	X	X	
	Support peer educators	Provide monthly peer educator stipends	X	X	X	X	X	
	Host "edutainment" community events (such as dances, music concerts, or sport competitions) to provide opportunity for knowledge exchange among young people	Host "edutainment" community events		X	X	X	X	
2b: Ministry of education policies revised to allow the school health curriculum to include messages on SRH, including prevention of teenage pregnancy	Advocate with Ministry of Education to implement a school health curriculum that includes messages on SRH, including prevention of teenage pregnancy	Hold a series of meetings with the Ministry of Education to encourage a FP curriculum		X				Existence of supportive adolescent and youth SRH policies