Costed Implementation Plan Resource Kit

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

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Produced by:

K4Health
Knowledge for Health

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Overview of the Guide

About this Guide

This guide is part of a series of CIP Resource Kit. It is intended to provide systematic and practical guidance for articulating the family planning (FP) interventions, results (goal, outcomes, and outputs), strategic priorities, and implementation plan— which together make up the CIP technical strategy. Before developing a CIP technical strategy, country stakeholders should determine readiness to develop a CIP (see **Box 1**). The processes described in this guide are based on the experience of 42 countries that as of January 2022 have developed at least one national CIP (eight countries have developed more than one CIP). It incorporates known methodological frameworks for project design and strategic planning, including the logical framework approach and the results framework.

BOX 1: Deciding to develop a CIP

Engaging in the CIP process is an investment, and countries should weigh the value a CIP might add to the current program against the resource commitment necessary to complete the process. Country stakeholders should make informed decisions to develop a CIP, taking into consideration the existence of other strategies, as well as the country's capacity and commitment to execute the plan, among other factors. The tool, *Deciding to Develop a Costed Implementation Plan: Seven Considerations to inform Country Decision-Making,* can help a country self-assess and reflect on its readiness for a CIP. Country stakeholders should use this tool or other approaches to determine whether a CIP is right for their needs before embarking on developing a CIP technical strategy.

Changes to the Guide

This guide was originally published in 2015 and was updated in 2018 and again in 2022 as part of a continuous learning and adaptation process. The most recent revisions made in 2022 focused on clarifying the flow of the guide, providing more guidance on setting clear strategic priorities within the technical strategy and incorporating sub-national considerations, and providing flexibility in approaches across the process of developing of a CIP technical strategy.

Intended Users of the Guide

The development of a CIP is a highly participatory process, involving a range of stakeholders and technical experts, and led by the country government. This guide is intended for use by the core technical team facilitating the CIP process at a country or sub-national level, although they can and should consult other experts both in and beyond the country. The core technical team, sometimes called the Technical Support Team (TST) usually reports to a CIP Taskforce, which represents the governance and decision-making body of the CIP development process. Each country may define roles differently depending on their processes for developing strategic plans. Sample composition, roles and responsibilities for 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 technical strategy development process, while allowing for the flexibility to tailor the process to different country contexts and needs. It can be adapted for use to develop CIPs at the subnational level-- for example, at the state or district level (see **Box 10** at the end of this guide for more detailed guidance on how to incorporate sub-national considerations). This guide also outlines opportunities for strategic priority setting throughout the process of developing a CIP technical strategy, which stakeholders have noted is an essential element of a successful CIP (see **Box 2**). **Box 3** and **Box 6** detail specific approaches to set strategic priorities during the situational analysis and results formulation stages. Countries may choose their approach to prioritization based on their context and needs.

BOX 2: Setting Clear Strategic Priorities in a CIP

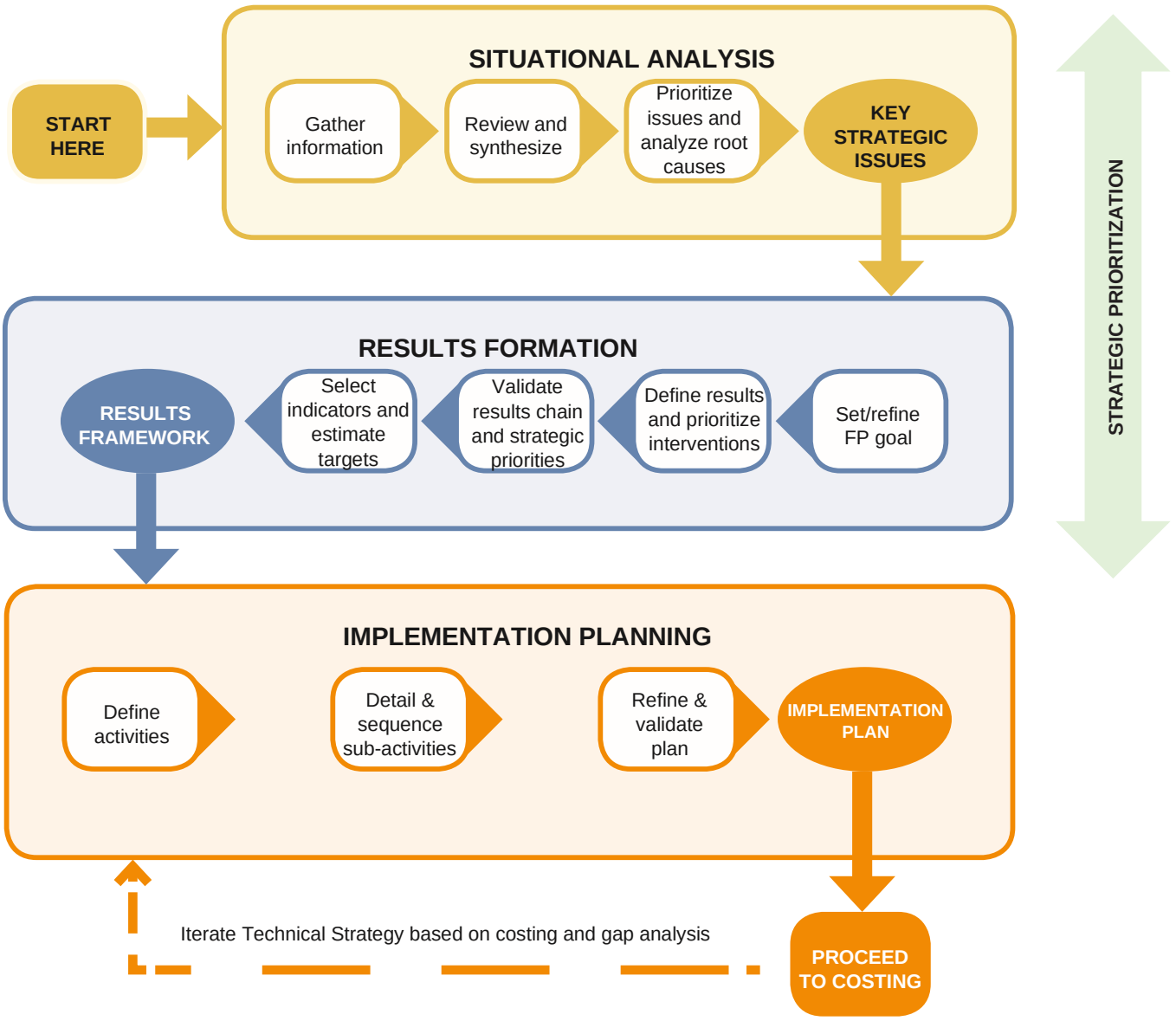
Lessons learned from scores of CIPs across countries revealed that stakeholders have valued, and donors have aligned more easily behind, CIPs that articulate and justify clear strategic priorities. Some countries have developed more than one CIP in the timespan since the 2012 London Summit. Observers shared that where the second CIP had a sharper set of strategic priorities, it created greater partner alignment at both national and subnational levels. Given limited resources for FP, both financial and in terms of capacity, priority setting helps to ensure that efforts are focused where they will contribute the most to improving access, quality and equity, among other components of a rights-based approach to FP. Furthermore, articulating strategic priorities transparently, with a justification for choices made, fosters collaboration and commitment to these priorities, and extends the benefits of CIP efforts to other strategic documents, such as Global Financing Facility (GFF) investment cases or national social sector strategies. This justification should clearly identify the value for additional targeted investments to accelerate growth in contraceptive prevalence or another high-level aim of the CIP (e.g., preventing adolescent pregnancy).

This guide corresponds with **Step 3 (Conduct a Situational Analysis)** and **Step 4 (Develop a Technical Strategy and Implementation Plan)** of the 10-Step CIP Process. This document begins by outlining the theoretical foundations for a CIP technical strategy and key considerations during the process. Following the introduction, each step of the process is presented in more detail, including a description of the step (the "what") followed by recommendations for how to implement (the "how"). **Figure 1** illustrates the overall process to develop a technical strategy that this guide further details. The guide also includes several tools, templates, and other resources recommended for use throughout the CIP development process. Tools are included as either Web-based links or appendices. A full library of additional resources can be found as an appendix in the *10-Step Process for CIP Planning, Development, and Execution* resource.

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.

Figure 1: Process Map for Developing a CIP Technical Strategy



Depending on the needs and contexts of different countries, the process to develop a CIP technical strategy (outlined in **Figure 1**) may be adapted. A few examples are included below:

- *Countries with existing CIPs:* Countries with existing CIPs may have conducted, or are considering, a final and comprehensive end-line review of the progress made toward achieving the CIP goal and objectives. An end-line review can provide useful baseline data/information and recommendations for a future CIP. In some cases, an endline review can replace a situational analysis or reduce its scope.
- *Countries with existing FP strategic plans:* Some countries may already have FP strategic plans in place but have decided to develop a detailed CIP. Countries such as Zimbabwe decided to develop a CIP based on its FP strategy. In this context, the situational analysis and result

formulation action steps can be skipped, and the CIP process can start from implementation planning.

A number of countries have used the *FP Goals Model* to support the development of the CIP technical strategy. The *FP Goals 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. **Appendix 2** details how the *FP Goals Model* can be applied throughout the CIP development process, and **Appendix 3** provides a case study of how the *FP Goals Model* was applied in the Tanzania National Family Planning Costed Implementation Plan 2019-2023.

Introduction

Overview of a CIP Technical Strategy

A Costed Implementation Plan (CIP) 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, interventions and strategic priorities, and an implementation plan outlining how and when results will be achieved. 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 in the CIP Resource Kit 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)
- *Comprehensive Human Rights-based Voluntary Family Planning Program Framework* (FP2030, UNFPA and What Works Association, 2021)

Process for Developing a CIP Technical Strategy

SITUATIONAL ANALYSIS

What is a Situational Analysis?

A situational analysis provides a comprehensive perspective of the FP context in order to inform strategic actions to improve the FP program, including taking a rights-based approach to voluntary FP. This step relies on the collection of new data and leveraging existing data on the past and current status of the FP program to investigate prioritized sticky issues, surface problems, identify their root causes, and strategically select opportunities for growth. By providing a deeper understanding of the context, the situational analysis facilitates a shared understanding across stakeholders, feeding into the development of a CIP technical strategy that is well-calibrated to work with factors that drive and block progress toward achieving the country's FP goals, forming the foundation upon which subsequent action steps build, and ultimately leading to results.

Situational Analysis Analytical Framework

The process for developing a situational analysis will vary depending on whether this is an initial or subsequent CIP, what existing data and analyses can be leveraged, and what resources are available. In most cases, some level of situational analysis has been done for a previous CIP or other existing strategies, so this process will likely focus on updating the last situational analysis with new data and information on relevant changes to the FP environment, including recommendations from the final review of the previous CIP. **Box 4** provides more detail on opportunities for strategic prioritization during the situational analysis.

BOX 3: Priority Setting During the Situational Analysis

"We made a summary of the state of priority challenges by strategic axis, the challenges that have been taken up, the challenges have been reduced, and the challenges that persist. We had a total of 19 challenges, of which it was estimated that 13 were reduced and six persisted."
Simplice Toe, PROMACO, Burkina Faso
Family Planning Costed Implementation Plan Resource Kit: What We Heard.

Prioritization is a critical throughout the CIP development process. Similar to the approach Burkina Faso took (detailed in the quote above), a country may begin narrowing their efforts to focus on priority areas as early as the situational analysis. For some contexts and needs, a situational analysis that tries to catalog and document all aspects of the FP landscape may not be as useful as one that attempts to delve into topics and issues that have already been identified as pertinent.

If a country has a recent comprehensive review of the FP program, such as an end-line review from a past CIP, the TST may prioritize questions to explore during the situational analysis based on gaps, areas of

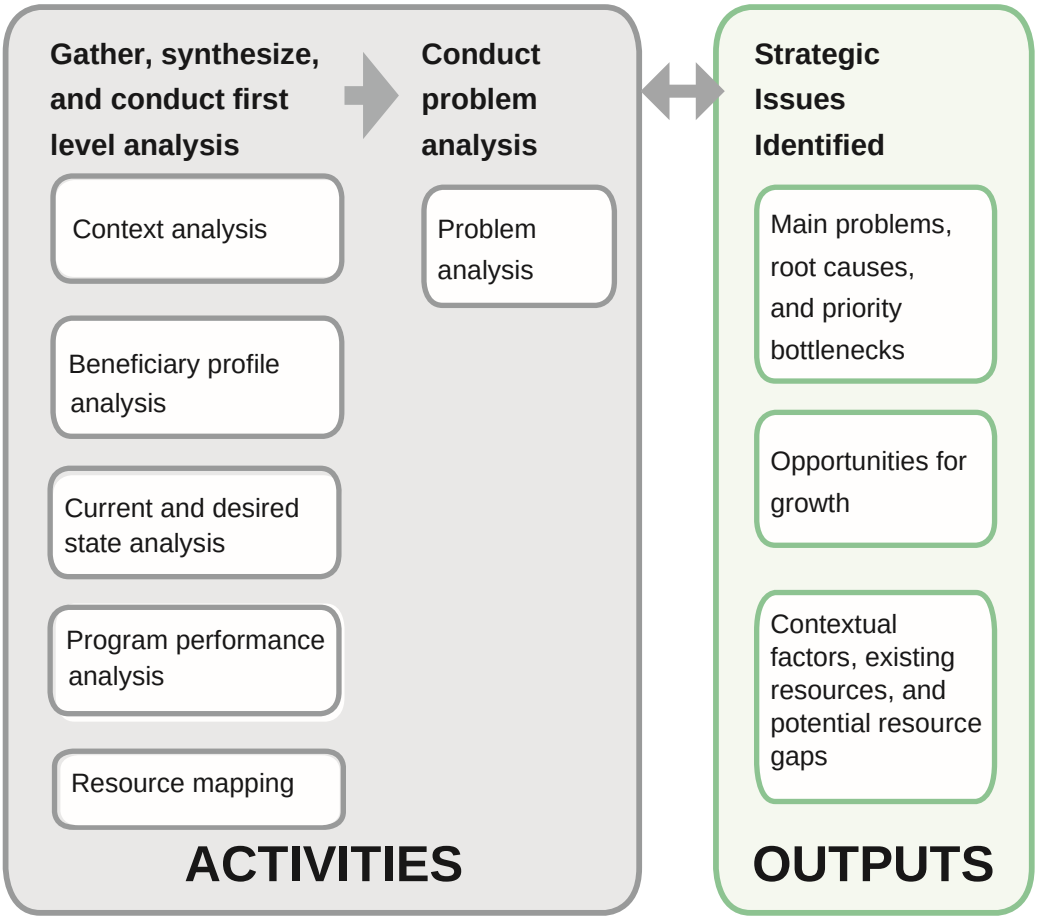
improvement, or opportunities noted in the existing review. For instance, there may be strategic priorities that were neglected or underperformed in the previous CIP cycle that could guide the situational analysis. In this context, a situational analysis may not need to exhaustively cover the full scope of areas related FP, but rather be guided by key strategic questions or gaps from past CIP implementation. See *Conducting a CIP End-Line Review: A Guide for CIP Stakeholders* for more information on end-line review purpose and methodology.

The TST will also prioritize problems and associated causes the CIP will need to address during the situational analysis. This prioritization could be based on scope/feasibility and potential impact on the FP goal. For example, teenage pregnancy is a problem associated with multiple causes. Stakeholders would need to prioritize which of these causes should and can be tackled, and whether teenage pregnancy should be addressed at all.

Prioritization at this stage can help to lay the groundwork for identification of clear and catalytic strategic priorities in the results formulation stage. See **Box 6** for more detail on prioritization during results formulation.

When existing data is limited – indicating a gap in evidence about the status of the FP program – and/or there is bandwidth for a more rigorous approach to the situational analysis, the below analytical framework **(Figure 2)** can guide the process. This analytical framework 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. The TST can use this analytical framework to determine how existing data can be assembled and reviewed, and where there may be gaps that require new data collection. **Appendix 4** contains detail on the type of information that is included in first-level analyses (context analysis, beneficiary profile analysis, current and desired state analysis, program performance analysis, resource mapping).

Figure 2: Analytical Framework for a Situational Analysis



How do we do a Situational Analysis?

The situational analysis involves three major tasks: a) gathering information; c) analyzing and synthesizing information; and c) conducting a problem analysis to generate root causes and to select key bottlenecks.

Gather Information on current FP context, programs, and resources

Depending on the availability of relevant, up-to-date information, the TST may use several methods – including desk reviews, stakeholder analysis, secondary data analysis, and expert consultations – to gather quantitative and qualitative information to complement existing data.

Detailed guidance on the types of information and analyses that can be included in the situational analysis can be found in **Appendix 4,** and **Appendix 5** provides a comprehensive list of guiding questions to inform the situational analysis. It also includes suggested additional resources. The SEED Assessment Guideis an additional resource that includes guides for conducting desk reviews and questionnaires for key informant interviews with a variety of stakeholders. The sequence of data collection and analyses will vary depending on the context, resources available, and which questions need to be answered.

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 4** for more on conducting expert consultations).

BOX 4: Conducting Expert Consultations

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. 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 *Team Roles and Responsibilities for CIP Development and Execution* tool describes in more detail the composition and roles of the SAGs.

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 data useful for the different analyses mentioned above, as well as the *FP Goals Model* if that is being applied (**Appendix 2**). This data will also feed into setting indicators during results formulation. If there has been a previous CIP, data from CIP performance monitoring and endline reviews should inform the situational analysis. Other common data sources to inform the situational analysis include country HMIS/LMIS; FP2030 or Track20 Country Data; National Surveys (DHS, MICS, PMA); facility surveys (SDP or SPA); expenditure surveys (NHA, FPSA); indices on FP environment (AFPE, NCIFP); and published peer-reviewed journal articles. 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 5**).

BOX 5: Grounding a Situational Analysis in Human Rights

The global FP community, via FP2030, 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
- Accessibility
- Acceptability
- Availability
- Empowerment
- Equity and non-discrimination
- Informed choice
- Quality
- Transparency and accountability
- Voice and participation

FP2030 and partners have many resources available on their website to support countries as they strive to strengthen a rights-based approach. Among these are 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, and the National Composite Index on Family Planning (NCIFP) which measures the existence of rights-based FP policies and program implementation Additionally, the Programme Assessment Tool for a Human Rights-Based Approach to Voluntary Family Planning can be used to in the situational analysis. Other resources to support integration of rights can be found in the *Rights-Sizing Family Planning Toolkit* in the CIP Resource Kit.

Review and Synthesize Information

Throughout this process, the TST will be collecting, analyzing, 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 FP2030 also highlight opportunities for growth. Similarly, the TST may 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, level of fragility, human resource availability, or urbanization.

As the TST collects information, it also reviews and systematically classifies the information into key issues under a set of thematic areas (i.e., demand, service delivery, contraceptive commodity security, and enabling environment) and sub-areas. During the information gathering stage, causal factors as well as recommendations for solutions may arise and should also be classified accordingly. See **Appendix 7** for the "Issues and Solutions Matrix" template, which can be used to classify information.

The TST is encouraged to distill the situational analysis into a format that is most helpful for the team to formulate and articulate strategic priorities. This may be a PowerPoint presentation that highlights the existing goals, current trends and program status, resources, and most critical challenges, barriers, and missed opportunities. It is also helpful to write up working versions of the relevant sections of the technical narrative.

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 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 8.** 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 the implementation plan. 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 which is further described in the following section on results formulation.

At the completion of the situational analysis, 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 steps.

RESULTS FORMULATION

What is Results Formulation?

With the priority problems diagnosed and articulated, various analyses conducted, and baseline information in hand, stakeholders can now engage in a process of setting strategic priorities to develop a strategy for achieving desired goals.

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 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 linked to interventions. A result chain is organized around an outcome (each thematic area may have more than one outcome) and has several outputs and interventions. Several result chains, together, form a results framework. In the process of formulating a results framework, there are multiple opportunities for prioritization (**Box 6**).

BOX 6: Priority Setting During the Results Formulation

During results formulation, strategic priorities will emerge from a broader range of interventions, outputs and outcomes. Given limited financial resources and capacity, identifying clear strategic priorities helps to ensure that efforts are focused where they are needed most. Strategic priorities may begin to be identified as early as the situational analysis and/or may emerge while the TST works with stakeholders to formulate and visualize the key results (outcomes and outputs) and interventions that address the problems, root causes, opportunities and bottlenecks laid out in the situational analysis. Strategic priorities can be reflected in a CIP Map, a one-page summary that articulates the CIP strategy with the refined list of strategic priorities that are catalytic to achieving the CIP goal (more guidance on a CIP Map and a sample can be found in **Appendix 9**).

How do you Formulate and Visualize Results?

The formulation of a results framework involves four major tasks: (a) setting or refining the FP goal; (b) defining results and prioritizing outcomes, outputs and interventions; (c) validating the results chain and strategic priorities; and d) estimating performance targets for results, including commodity requirements.

Set or Refine the 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 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. Further guidance on goal setting can be found in the FP2030 measurement learning series brief on Setting Goals to Measure Progress. As the goal is being set, it is important to situate the goal in the context of ensuring that programming adheres to rights-based standards and principles.

Modern CPR (mCPR) for all or only married women, unmet need, and couple 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 10**). This guide generally recommends using mCPR for all women, which is the indicator tracked by FP2030 and Track20.

When a FP goal is set—for example, in existing health or development strategies as a part of a wider RMNCH strategy, or as a part of FP2030 or other global commitments—the TST should have reviewed the feasibility of the goal as part of the the situational analysis. 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 3**.

When no existing goal is identified, or it is determined that the existing goal is not feasible or suitable, there are many tools that can guide the process to establish a data-informed goal. **Appendix 10** has detailed guidance on how to set or amend realistic, data-informed goals, including suggested tools.

Causal factors

- Social norms and beliefs, as well as myths and conceptions around FP hinder use of contraceptive methods
- Persisting desire for large families
- Experienced or perceived method-related side effects
- Cultural and religious ties serve as barriers
- Partner opposition to FP use.

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 may use a 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.

Define and Prioritize Outcomes, Outputs, and Interventions

Outcomes, outputs, and interventions are derived from the problems, causal factors, bottlenecks and opportunities identified in the situational analysis. As the TST works with the SAGs to identify and prioritize what outcomes, outputs, and interventions will be included in the CIP, strategic priorities will emerge. In practice, this process is often more iterative than linear. In some cases, the process may begin with defining results, and from there proceed to identifying interventions and strategic priorities. In other cases, interventions may be mapped and prioritized, followed by the detailing of outcomes and outputs linked with the interventions. Likely, this will happen in parallel: as the TST converts problems and causes into results, interventions will emerge and will inform the identification and prioritization of results, and vice versa. This process roughly follows three interconnected sub-steps:

(i) ***Convert problems/causes to results.*** Under each thematic area, the key problems/causal factors can be re-framed as results/positive achievements. The key problems are converted to high-level results (usually outcomes) while causal factors become outputs and interventions. **Table 1** provides an example of converting problems into results, adapted from Tanzania's

National Family Planning Costed Implementation Plan 2019-2023. It's important to note that with this example, as with many CIPs, outputs are the expected results achieved from the implementation of interventions, which may differ from common definitions of outputs. When this process is completed, the TST and stakeholders should have one or more result chains for each thematic 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 1: Illustrated Conversion of Problems into Results (adapted from Tanzania's National Family Planning Costed Implementation Plan 2019-2023)

Key Problems/Causal Factors	Results/Positive Achievements
Problem: Low demand for contraceptives **Causal factors** • Social norms and beliefs, as well as myths and conceptions around FP hinder use of contraceptive methods • Persisting desire for large families • Experienced or perceived method-related side effects • Cultural and religious ties serve as barriers • Partner opposition to FP use. **Gaps** • Absence of national FP social and behavioral change communication (SBCC) strategy • SBCC efforts not targeted in terms of gender, age, life cycle, or geographical location • Insufficient use of commercial marketing approaches • Low levels of community involvement to support SBCC	**Outcome:** Increase total demand for contraceptives **Outputs** • People have accurate knowledge and self-efficacy to adopt a positive behavioral change to practice FP • Positive shifts in social norms and attitudes to foster healthier behaviors and beliefs around contraception and its health and economic benefits **Interventions** • Develop a national FP social and behavioral change communication (SBCC) strategy, including adapting existing and developing new materials, based on an assessment to identify social norms that impede FP use in priority regions • Tailor messages and delivery channels for specific regions and groups (i.e. postpartum women and youth) • Equip CHWs with enhanced and improved knowledge and skills to offer FP information, make referrals, mobilize clients for outreach activities, and support and track FP users **Cross-Cutting Interventions** • Integrate SBCC messages and tools into CHW training and activities, including service delivery supervision • Increase coordination between FP Subunit of RCHS with the Health Communication Subunit of the Health Promotion Section

Outputs

(ii) ***Identify evidence-based interventions that lead to outcomes.*** As the TST is converting the problems and causal factors into outcomes and outputs, they are also identifying and prioritizing evidence-based interventions that can address these root causes and lead to the desired outputs and outcomes. Interventions should be linked to outputs and outcomes, feasible and relevant for the country or subnational context, comprehensively address the problems, and able to make an impact towards the FP goal.

There are multiple resources that can support the generation and prioritization of interventions. One go-to resource that should be leveraged in this process are the High Impact Practices (HIPs) for FP, which include short briefs and planning guides on 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. Other resources to support identification of interventions can be found in **Box 7.** Additionally, The *Prioritization Matrix Tool*, described in **Appendix 11**, can help stakeholders make decisions by weighing specific interventions against a set of criteria, including evidence of impact.

BOX 7: Additional Resources for FP Interventions

Elements of FP Success	This report 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 of international FP.
K4Health Toolkits for FP	This collection 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.
Rights-sizing Family Planning Toolkit	This toolkit lists potential interventions related to the rights principles and standards. These interventions can be found on pages 26-41.

For the purpose of the CIP, results chains are often developed by thematic area (e.g., demand, service delivery, contraceptive commodity security, and enabling environment). However, in many cases, interventions, and achievement of related outcomes and outputs to support them, will require work across multiple thematic areas. Additionally, interventions themselves may support multiple outcomes (see **Appendix 3** for an example from Tanzania, and **Table 2** for illustrative cross-cutting interventions). For example, achievement of an outcome of "increased access to contraception among young people" may primarily fall under service delivery but may also require policy changes in the enabling environment to ensure youth, especially unmarried youth, are able to receive services, or demand focused interventions to address community norms that may limit access. Similarly, an intervention such as expanding contraceptive access through drug shops may require activities under service delivery, enabling environment, commodity security and demand. Outcomes and related outputs and interventions can be placed under the thematic area that most aligns with the outcome, or a specific outcome can also be developed, especially for strategic priorities.

(iii) *Identify Strategic Priorities*

As the results framework is being developed, Strategic Priorities will emerge that require focused implementation, financial resource allocation, and enhanced oversight and performance monitoring during CIP execution. Strategic priorities should address the bottlenecks identified during the problem analysis and/or will accelerate achievement of the desired goal. It is important to ensure that the strategic priorities reflect those over which the FP program has direct control or influence. **Table 2** provides a framework for considering prioritization based on multiple criteria. The criteria shown below can be adapted based on a country's context.

TABLE 2: 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 process to identify strategic priorities often takes the form of brainstorming sessions facilitated by the TST with the SAGs (through one or more meetings or consultations). During 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 FP2030 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.

The strategic priorities can either be displayed in a one-page CIP map (see **Appendix 9**) or within the results framework by using colors, symbols, or text to identify them (see **Appendix 12** for a sample results framework). They will also be included within the Performance Monitoring Plan (PMP) for the CIP developed during **Step 9 (Design and implement performance monitoring mechanisms)**—the *Performance Review Process Guide* provides

detailed guidance on how to develop a PMP for a CIP. Identifying the strategic priorities at this stage allows stakeholder to come to consensus on what must be included in the PMP.

Validate the Results Chain and Strategic Priorities

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, like the High Impact Practices. The TST and SAGs should be familiar with these resources before formulating the results and interventions.
- **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 FP 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 interventions could include: (1) provide vouchers to young people to subsidize the cost of contraceptive services or (2) community-based interventions targeting parents and caregivers. Therefore, to complete the task, the group may revise statements, add new outputs and interventions if these seem to be relevant and necessary to achieve the outcome, and/or delete outputs and interventions that do not seem suitable or necessary.

Select Indicators and Estimate Targets for Outcomes and Outputs

Once stakeholders have formulated results, interventions, and strategic priorities, the next step is to assign indicators and estimate targets for the outcomes and in some cases, 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 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 13** provides illustrative indicators for the results framework example used in this guide. It uses indicators from the FP indicator database. **Box 8** outlines several factors to be considered while assigning indicators, and **Table 3** provides a quick checklist that can be used to review the quality of the indicators in a CIP.

BOX 8: 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.

When possible, indicators should utilize data that is already routinely collected in order to allow for frequent monitoring of progress. If indicators are used from surveys that are only conducted every 5 years, it won't be possible to know how things are progressing during the implementation phase. Using indicators from a country's HMIS/DHIS2 and LMIS system means that monitoring can be built into existing scorecards and dashboards.

If there is an outcome/output/strategic priority for which no data is collected, new indicators may be proposed. However, consideration needs to be given for what it would take to roll out the new indicators. For example, if a country has no postpartum family planning (PPFP) indicator in their routine monitoring system they may wish to explore introducing a new indicator (consulting global recommendations). This could mean implementing a whole new PPFP register, or, simply adding a field to existing FP registers to note if clients are postpartum or not. Consideration is needed for how this data will be collected at the facility level, and how it will be aggregated up into centralized systems.

In some cases, new indicators can be constructed from existing data elements that are already collected. For example, one country's DHIS2 system separated FP visit data according to mobile outreach versus in clinic provision. Based on these existing data elements, a new indicator was constructed to calculate the share of FP services provided through mobile outreach to monitor the transition of the provision of LARC from mobile outreach teams to clinic staff.

TABLE 3: 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 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 4** illustrates this target estimation approach.

TABLE 4: 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%			
# maternity providers to be trained/year [standard 2/facility]	1500	1500	1500	1500

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 √ , and CastCost, 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. In cases where a multi-year national quantification exercise has already been conducted, the TST may consider using that quantification rather than estimates developed separately for the CIP.

Finalizing the Results Formulation

Upon completion of results formulation, the TST and stakeholders will have a complete and validated results framework and CIP Map that reflects interventions and strategic priorities that are both driving growth and that require enhanced monitoring, as well as indicators and performance targets for outcome and output level results. At this stage, the TST and stakeholders may also have integrated sub-national planning and prioritization into the technical strategy. See **Box 9** for more considerations and approaches to sub-national planning.

BOX 9: Sub-National Planning and Prioritization

In most contexts, full sub-national CIPs are not necessary if regional variation is appropriately considered in the national CIP. Results from the situational analysis can help countries determine the level of geographical variation needed in the CIP. In some cases, there may be subnational levels with larger programmable budgets or external resources. In this case, additional local priorities can be added to their workplans or longer-term development plans.

Sub-national consideration should include consultations with these levels to ensure that not only are interventions selected based on criteria like disease burden, effectiveness, costs, and fairness, but also on principles of acceptability and feasibility. Explicitly linking sub-national planning instruments like annual work plans with implementation priorities will ensure that they are budgeted for and will be implemented.

When planning for sub-national variation, consider how the distribution of strategic priorities in the national CIP varies within a country and using this information to decide how implementation will be distributed at the subnational level. There are two approaches to sub-national planning that leverage national strategic priorities. Countries should choose the option that best reflects the needs identified in the situational analysis.

1. *Difference in scale of implementation*. This approach looks at each region's performance in the national strategic priorities and then differentiates scale up to address underperforming areas. This approach gives different weight to each priority in each region, based on their current situation.
2. *Priority Regions*. This approach identifies regions that perform below the national average across several key indicators. These regions are then selected as 'priority' geographies where interventions can be more intensive for all national strategic priorities.

In developing a national CIP, regional or district summary briefs may be useful to contextualize the results framework for each region/district. For example, if eliminating stock outs is a national strategic priority, a summary brief for Region A could show stock out data for that region relative to national data so that the region can determine to what degree a focus on stock outs should be prioritized (aligning with the "difference in scale of implementation" approach described above).

IMPLEMENTATION PLANNING

What is an Implementation Plan?

Once the results framework and CIP Map have been completed and validated, the next step is to develop an implementation plan to describe how the results framework will be achieved through implementation of specific activities. The implementation plan (see sample in **Appendix 14**) consists of matrices for each thematic area, including the following items for each outcome:

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

In the implementation plan, the TST defines the inputs of the activities and assigns resource estimates, forming the basis for costing the plan. The timeframe for these activities may vary depending on the context (see **Box 10** for potential adaptations).

BOX 10: Adaptions to Implementation Planning

Depending on the needs, resources, and bandwidth, the TST may decide to develop a detailed implementation plan for only the first one to two years, rather than the entire five-year CIP period. This is a lighter touch approach and allows for the detailed activities to be revisited on an annual or bi-annual basis and integrated into ongoing planning processes.

Further, when possible, implementation planning for the CIP should be linked with existing planning processes. In contexts where a robust annual planning process already exists, a separate implementation plan for the CIP may not be needed. Rather, the CIP goal, outcome, and outputs can be used to inform the existing planning processes. This is true at both the National and Sub-National level.

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 activities, (2) detailing and sequencing sub-activities, and (3) refining and validating the implementation plan. Activities and sub-activities are generated for each of the outputs developed in the results framework. The TST and SAGs may wish to put special focus on the outputs that were selected as strategic priorities, or to which the strategic priorities contribute.

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 FP 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 14**.

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 the High Impact Practices and those available in K4Health Toolkits 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 thematic areas all suggest numerous activities in the first year. When all the activities across different thematic 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.

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

Refine and Validate the Technical Strategy and Implementation Plan

Refinement and validation of the technical strategy is a highly iterative, continuous process throughout the development phase. After the implementation plan is finalized, the TST and monitoring and evaluation officer reviews the indicators to assess if the indicators need to be refined to aid in ensuring regular performance monitoring of the full technical strategy. 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 14.** The format and organization may look different 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. If the TST has decided to focus the implementation plan on two years rather than five years, the timeline should reflect that.

At this point, the TST should write up the narrative descriptions of outcomes, outputs, interventions 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 1** provides a sample table of contents for a CIP. The TST presents the strategy for each thematic area to the corresponding SAG for review, and the full technical strategy for final review by the CIP Task Force. During this time, the substantive portion of the CIP document is edited and polished for presentation to the stakeholders. This process often overlaps with **Step 5 (Estimate Costs and Resource Gap and Iterate Technical Strategy)**, as costing and mapping existing resources is essential to refining and validating the technical strategy.

Next Steps

Upon completion, refinement and validation of the CIP technical strategy, the process continues with **Step 5 (Estimate Costs and Resource Gap and Iterate Technical Strategy)**. Further guidance for costing—including defining inputs and estimating resource requirements—are addressed in other tools in the CIP Resource Kit, namely the *CIP Costing Tool* and corresponding user guide. As a reminder, the process of moving from implementation planning to costing should be iterative. For example, after costing and gap analysis has been done, it is important to review the costs of delivery and available resources 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. If the detailed implementation plan only covers two years, please see **Appendix 15** for guidance on how to adjust the approach to costing to ensure estimation of costs for the entire plan.

In addition to these steps, the TST may decide to estimate the impact of achieving the CIP's FP goal to bolster resource mobilization efforts. Estimating the health and development impact of achieving the CIP's FP goal on health indicators can help articulate the resulting financial savings to the healthcare system. ImpactNow, and FamPlan are tools that can be used to estimate impact. 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.

As the CIP development process continues, the TST will finalize the narrative document of the CIP, the bulk of which is the Technical Strategy. When combined with appropriate forwards and introductions, and necessary appendices, it will be signed and officially launched (see step 7 of 10-step process).

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APPENDIX 1

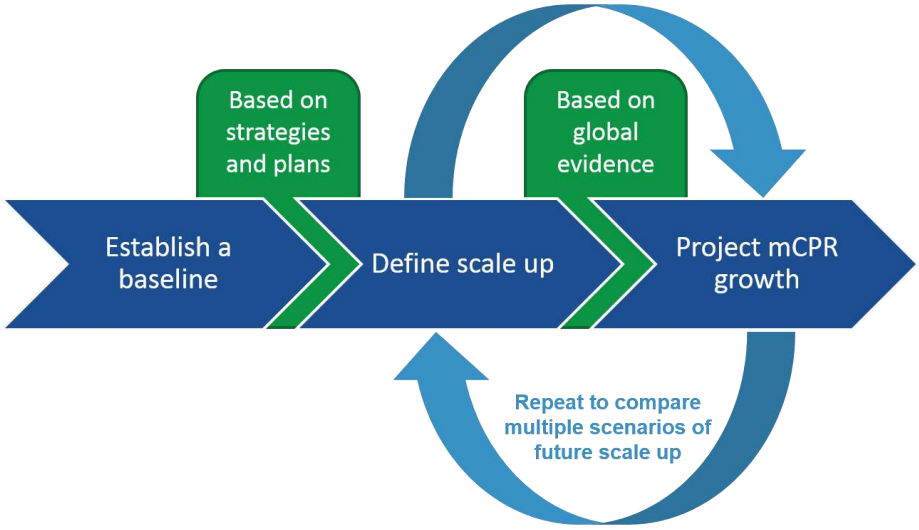
Sample Table of Contents

APPENDIX 2

Using the *FP Goals Model* for CIP Development

The *FP Goals Model* is an innovative model designed to improve strategic planning. The *FP Goals Model* 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.

Appendix Figure 1: *FP Goals Model* Process Map



Establishing a Baseline:

- Data is collected from a range of sources (surveys, program reports, HMIS/LMIS Systems, and key informant interviews).
- This data is used to understand what FP efforts and programs are currently underway.

Defining Scale Up:

- Based on strategies and plans and discussions with stakeholders, a scenario is developed in which scale-up and implementation of new programs are defined.

Projecting mCPR Growth:

- Based on the scale of those interventions defined in strategies and plans, coverage of those interventions is estimated.
- Based on global evidence on the effectiveness of various types of FP interventions, the impact of the coverage on mCPR growth is projected.
- This process of defining scale-up and projecting mCPR growth is repeated to provide multiple scenarios, with varying levels of scale-up of existing programs and various options for implementation of new programs.

If an *FP Goals Model* application is done as part of developing a CIP, the *FP Goals Model* can help support multiple steps throughout the process.

Situational Analysis: the baseline data collected for the *FP Goals Model* analysis provides a useful snapshot of current performance of the FP program across a wide range of areas. The data and analysis done as part of the *FP Goals Model* baseline can be closely integrated into the situational analysis process.

Results Formulation: multiple projections are usually developed as part of an *FP Goals Model* application. Reviewing and agreeing a final scenario can be useful in establishing an mCPR goal, since the model projects the resulting mCPR. It can also be used to sense-check the ambition on existing FP Goals. Finally, the scale up of interventions in the *FP Goals Model* can be a key input to informing prioritization by quantifying the potential gains that can be achieved through scaling up different interventions.

Performance targets for certain outcomes and outputs can be generated from the *FP Goals Model* 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 translated into a number of facilities based on data collected for the *FP Goals Model* about the number of health centers in the country.

APPENDIX BOX 1: Accessing the *FP Goals Model*

Learn more about the *FP Goals Model* at: www.track20.org/pages/our_work/innovative_tools/FPgoals.php

The full *FP Goals Model* is not currently publicly available, but the interactive FP Goal Lite Model can demonstrate how initiating or scaling up different interventions might affect a country's modern contraceptive prevalence rate among all women of reproductive age. This tool is meant to provide a quick glance at results based on select interventions. It does not replace the more robust results you would get from a full application of FP Goals.

If you are interested in a full FP Goals Model application for your country, contact Track20. Learn more about Track20 models and approaches at www.track20.org.

APPENDIX 3

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) 2019-2023 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 FP 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 2019-2023. 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 2019-2023.

In June 2017, data on key FP 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 2019-2023 situational analysis.

In July 2017, a Technical Support Team (TST) was established to coordinate the development of the NFPCIP 2019-2023. 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 2019-2023 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 2019-2023 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 FP 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 FP, 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 2019-2023.

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 2019-2023 implementation period. Finally, the RCHS circulated multiple draft versions of the NFPCIP 2019-2023 to key stakeholders and partners before it was finalized.

APPENDIX 4

Conducting First Level Situational Analyses

Depending on the needs and bandwidth of the country, the situational analysis may explore all or some of the below areas of first level analysis.

1. ***Context analysis*:** Refers to the analysis of the political/policy/legal, financing, and socio-cultural, and fragility 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. Financing Environment: This refers to the country's financing situation that affect the country's ability to meet the contraceptive needs of its population. Understanding prospects for enhanced domestic resource mobilization requires exploring national and subnational public sector financing for FP, development 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, functioning of total market approaches, insurance coverage and use, and a general fiscal space for health. Understanding external financing needs to priorities, trends, and policies of various development partners and financing instruments. The Family Planning Financing Roadmap is a resource that can be used by the TST to identify relevant FP financing options given a particular country's context.

    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.

    d. Fragility context: This refers to the combination of exposure to risk and insufficient coping capacity of the state, systems, and/or communities to manage, absorb, or mitigate those risks. Many countries are considered fragile or vulnerable to fragility due to recurring shocks and stress, including conflict and violence, natural disasters, pandemics among others. Understanding of the vulnerability and resilience of a country is an important consideration in selecting and tailoring interventions. The TST can use the OECD State of Fragility platform as a resource to understand the multidimensional fragility context of a country, and adapt interventions accordingly.

The TST can use the Family Planning in Humanitarian Settings: A Strategic Planning Guide to help decision-makers through a strategic process to identify actions that improve FP access in places at risk of, experiencing, and recovering from crisis events.

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, gender, sexual identity, varying abilities), as well as fertility and contraceptive use preferences.

Given that the population of individuals of reproductive age (the primary beneficiary group for FP programs) is vast and 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. **Appendix Box 2** 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.

APPENDIX BOX 2: 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).

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, FP2030 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. **Appendix Table 1** below provides an example of a current/desired state analysis of goals.

APPENDIX 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, and extent by which key high impact practices for FP are currently implemented (i.e., coverage) and 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.* The National Composite Index on Family Planning (NCIFP), developed to support FP2020's efforts to improve the enabling environment for FP, measures both the existence of FP policies and program implementation, using 35 individual scores organized under five dimensions: strategy, data, quality, equity, and accountability. 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).

5. ***Resource Mapping:*** Resource mapping estimates the amount of financial resources that may be available to implement the programmatic interventions within the CIP. This exercise aims to determine how much is currently being budgeted for FP within the country; who is investing in and implementing FP programs; what interventions are being funded; and where the investment is going by geographic location. Mapping resources during the situational analysis supports iteration throughout the technical strategy design to right-size the scope of the technical strategy and will directly feed into the gap analysis that takes place during **Step 5** of the CIP development process. There are multiple methodologies and tools that could be adapted to answer these questions, with varying levels of effort (such as PAI's The Common Framework and GFF's Tools and Resources for Tracking COVID-19 Response Financing). One light-touch approach is to collect information on both program resources through a survey sent to relevant FP stakeholders. See **Appendix 6** for a sample survey that could be adapted to specific contexts and CIP needs.

APPENDIX 5

Situational Analysis: Guiding Questions and Topics for Information Gathering

Guiding Questions/Topics	Information Source	Tools/Frameworks
Context Analysis		
Political and Policy Environment • Do most FP program stakeholders believe that they have the unequivocal support of the highest levels of government to carry out their activities? • Are FP program stakeholders confident that they are receiving all possible support from government leaders? • Have political and program leaders succeeded in mobilizing the maximum amount of resources available from both national and international sources? • 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? • Do senior political leaders speak out effectively and often about FP and/or the impact of FP? • 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? • In what ways is FP featured in different health and non-health policies? • To what extent are FP-related policies implemented? • To what extent does the budgeting process facilitate or hinder implementation of a sound program? • What operational barriers exist in implementation of FP-related policies? • To what extent do existing policies respect/ protect/fulfill rights to accessing FP? Are there unnecessary barriers to access? • To what extent does the State embrace its role as duty-bearer of respecting, protecting, and fulfilling human rights? • To what extent do laws and policies promote and protect access to quality contraceptive information and services for all and equal treatment of all individuals? • To what extent does the privacy of individuals' health information enjoy legal protection? • To what extent does the state guarantee that human rights are exercised without discrimination of any kind? • To what extent is comprehensive sexuality education provided? • To what extent is a gender perspective at the center of all policies and programs affecting women's health? • To what extent do policies ensure contraceptive security, including access to a range of methods and service modalities—public, private, and nongovernmental?	• Policy documents • Budget cycle • Expert consultations	*Policy Checklist: Essential Elements for Successful FP Policies (HPP)* *Rights-sizing Family Planning Toolkit* *Programme Assessment Tool for a Human Rights-based Approach to Voluntary Family Planning (HRBA to FP)*

• To what extent do policies ensure that individuals are not subjected to incentives or policies that foster coercive provider practices, nor to medical eligibility criteria that create barriers to access? • To what extent are community members, including women from marginalized populations and youth, fully engaged in the formulation of policy affecting FP service delivery and in monitoring programs? *The recommended policy checklist tool (listed in the right column) provides a list of questions to guide the policy analysis.*		
Financing Environment • What are the trends in government financing of the FP program? • What is a reasonable expectation regarding governmental financing of the FP program? • To what extent can the country tap into local financing opportunities? How realistic is this? • What are some unusual or innovative financing mechanisms that have been used in other sectors? Could they be applied to FP? • To what extent are economic factors driving fertility preferences of the community? Which communities are most affected?	• Policies • Program documents • Expert consultation	*FP Financing Roadmap*
Social Environment • How do gender norms and inequalities influence women's access to and use of FP? • How do laws, regulations, policies, religious and cultural traditions, and other factors influencing gender norms affect women's status, equality, and reproductive rights? • 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? • 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)? • To what extent does the program consider the attainment of high quality of care (quality, accessibility, availability, and acceptability)? • 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? • To what extent are marginalized groups, especially women and girls, empowered to realize their sexual and reproductive health and rights (SRHR)? • To what extent do health committees comprised of community volunteers provide a link between service facilities and communities? • To what extent is use of FP by all population groups, including unmarried youth, culturally acceptable and supported by community and religious leaders? • To what extent are social accountability mechanisms in place, along with robust means of redress for rights violations?	• Legislative documents • Policies • Regulations • Program documents • Expert consultations	*Rights-sizing Family Planning Toolkit* *A Practical Guide for Managing and Conducting Gender Assessments in the Health Sector* *Voluntary Family Planning Programs: A Conceptual Framework*

Fragility Environment (Preparedness): • What types of hazards could disrupt FP services in parts of your country (e.g., natural hazards, conflict, public health emergencies/outbreak, etc.)? • Do national health and national emergency preparedness and response policies, plans, and budgets include preparedness and response for the *Minimum Initial Service Package for SRH (MISP)* in acute crisis situations? And comprehensive sexual and reproductive health (SRH) in protracted crisis situations? If yes, specify which MISP components are integrated, as well as the title, the region, and year of the policy/plan. • To what extent does the government consider SRH/FP a priority to be implemented during public-health emergencies such as natural disasters, conflicts, or infectious disease outbreaks (e.g., Ebola or COVID-19)? • What obstacles does the government face in prioritizing SRH/FP during public health emergencies or protracted humanitarian crisis situations?	*OECD State of Fragility platform* *Inform Risk Index country profiles*	*Family Planning in Humanitarian Settings: A Strategic Planning Guide* *20 Essential Resources: Family Planning and Reproductive Health in Fragile Settings* *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* *Ready to Save Lives Preparedness Toolkit* *MISP to Comprehensive Participatory Planning*
Beneficiary Profile Analysis		
Beneficiary Profile • What is the size of the total beneficiary population (for example, the number of women of reproductive age—15-49 years)? • What is the annual rate of population growth? • What age group constitutes the largest segment of the reproductive population? • What is the size of the beneficiary population that demand FP? • How many sexually active women of reproductive age are using modern contraceptive methods? • What is the percentage distribution of contraceptive users by FP method? • What is the percentage of FP service users who report using a public sector source? A private sector source? • What is/are the demographic profile(s) of women with an unmet need for contraception (considering education, residence, age, economic status)?	• National census data • Demographic and Health Surveys • Household surveys • MICS • PMA2020 research reports	
Trends in Population Growth and Contraceptive Use • What is the division of population by geographical location (rural vs. urban)? • What is the annual change in CPR (by age, geographical area, education, wealth quintile)? • What are the method mix trends? • What is the average annual change in use for each method? • Which methods are increasingly being used and which ones are not? • How has demand for FP and desired family size changed?	• National census data • Demographic and Health Surveys • Household surveys	

Current/Desired State Analysis		
• What is the current state of FP, described by key metrics? • What is the key FP goal(s) the country is trying to achieve, described by key metrics? • What is the required growth per year for the country to achieve its goal(s)? • What are historical rates of growth per year for the stated goal(s)? • To what extent is the required growth rate realistic given historical trends? • What are the key considerations for the program to meet the required growth rate during the period of the plan?	• Demographic and Health Surveys • Programmatic documents • Policy documents • Research publications • Stakeholder analysis	
Program Performance Analysis		
Supply **Contraceptive Security** • What are the key issues that need to addressed, and opportunities that need to be leveraged to facilitate a contraceptive security? **Service Delivery** • To what extent do service delivery standards meet international (e.g., WHO) norms? • To what extent are quality information and services provided equitably to all individuals without discrimination of any kind? • To what extent are the full range of contraceptive methods offered, including removal services for IUDs and implants, supported by adequate supply of commodities and equipment, competent staff and infrastructure? • To what extent are all clients informed and counseled to ensure they have accurate, unbiased and comprehensible information on which to base their FP decisions? • TO what extent are clients' rights and ability to make their own choices respected, protected and fulfilled? • To what extent are mechanisms in place to elicit input and feedback from clients and community members about service delivery? • To what extent do clients, as rights-holder, know and claim their human rights, challenge authorities if their rights are violated and have access to redress? • What are the key issues facing *each* 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 assessed differently. **Key Issues** to assess: • Availability of equipment, staff, and tools • Infrastructure • Provider skills and attitudes • Supervision • Existence of operational policy barriers	• Service Provision Assessments • Contraceptive Security Assessments • Program, Survey and Research Reports • Expert Consultations	Contraceptive Security: *Strategic Pathway to Reproductive Health Commodity Security (SPARCHS)* *RHCSAT: Reproductive Health Commodity Security Situational Analysis Tool* Private sector: *Assessment to Action*

• Functioning of QA/QI systems • Accountability measures that ensure that women's needs and desires are being met • Broad method mix offered • Extent of youth-friendly services offered • User fees • Counseling and client assessment • Functioning of integration of services		
Demand • 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? • To what extent are a variety of media channels used to execute the SBCC strategy? • To what extent are provider materials (for information, education, and counseling) adequate, up-to-date, and effective? • To what extent do the SBCC activities include interventions to affect positive social and gender norms? • To what extent do the SBCC activities incorporate new technology, such as ICT and other digital strategies? • To what extent do the SBCC activities engage champions, including religious leaders? • To what extent do the SBCC activities include commercial and social marketing approaches for promotion? • To what extent does the SBCC strategy recognize different segments of the beneficiary population, and respond to their different needs? • To what extent do the SBCC activities include advocacy interventions to gain general public support for FP?	• Program Documents and Reports • Expert • Consultations	*SEED Model*
Enabling Environment (Focus on program-level) • To what extent are resources (financial, human, technology, etc.) made available, allocated, and spent effectively and equitably to facilitate achievement of country FP goals? • To what extent are new financing mechanisms for FP (including health insurance, results-based financing) identified and tested? • To what extent is FP acknowledged as a development intervention, beyond health? • To what extent is the country program addressing social determinants that pre-disposes the population to risks of unintended pregnancies and contraceptive non-use? • To what extent is the country thinking comprehensively about a rights-based approach when serving their population? • To what extent is the FP program well-coordinated, at various levels, to improve effectiveness and efficiency of the program? • Do Ministry of Health staff have the requisite skills and resources to effectively run the FP program? • What barriers are there in executing existing policies?	• Program documents and reports • Expert consultations	*SEED Model*

Resource Mapping		
• For each theme (supply, demand, enabling environment) what is the estimated budget and/or expenditures for FP activities in the current calendar year? Be sure to capture budget/expenditures excluding indirect costs, salaries, and infrastructure • Are there any major FP programs or funding streams planned in the pipeline for the next five years?	• Expert Consultations • Stakeholder Surveys	*See appendix 6 for sample stakeholder survey*

APPENDIX 6

Sample Program Performance and Resource Mapping Survey

To facilitate the collection of data during the situational analysis on program performance and resource mapping, the below survey could be adapted to the context and needs of the specific CIP. From past CIP resource mapping experiences, it is often most effective when the request for information on resources and funding comes from the government rather than implementing partners, due to the sensitive nature of the data. In any situation, ensuring that the data will not be shared outside of the TST and will only be used to inform the CIP technical strategy is important to facilitate the exercise.

Sample Survey

		SKIPS
	Section I. Organization Information:	
1.1.	Name of Organization:	
1.2.	Name of Contact person/respondent:	
1.3.	Email address:	
1.4.	Telephone #:	
1.5.	Which programmatic elements of a FP program is your organization **currently working on/has worked** on in the past 3 years? (Mark all that apply) A. Service delivery – Improving availability and accessibility of quality FP services B. Demand generation – improving awareness, knowledge, and acceptance of FP; nurturing positive shifts in social and gender norms to increase acceptance of family planning C. Commodity Security D. Enabling environment E. SRH for Young people, 10-24 yrs F. Gender Equality/Equity G. Another FP program element……describe H. Not working/worked in FP	If G, go to 1.6
1.6.	If not worked/working in FP, what health areas is your organization working on in [insert country]? _____	
1.7.	What the source of funding (donor) for the work you are doing? A. UNFPA B. USAID C. Gates Foundation D. UNICEF E. WFP F. Other XXXX	

1.8.	Please mark ALL the [sub-national unit] where your organization has implemented FP activities in the past year A. [insert names of sub-national units] B.	
2.	**Service Delivery**	
2.1.	What service delivery High Impact Practices is your organization currently implementing: A. Task sharing B. Support to pharmacies and drug shops in FP service provision C. Social marketing D. Social franchising E. FP in humanitarian F. Post-abortion FP G. Immediate postpartum family planning H. Mobile outreach services I. FP and immunization integration J. Community-based family planning K. Youth-friendly FP services	
2.2.	Which other areas in service delivery is your organization currently working to improve: A. Capacity building of health providers for FP B. Applying quality improvement methods to FP services C. FP and HIV integration D. Other (please describe)	
2.3.	Please provide a brief description of your work in Service delivery	
2.4.	What is (was) the estimated budget and/or expenditures for these activities in the current calendar year _____? (***exclude indirect costs, salaries, and infrastructure) Currency_____Amount: _____	
2.5.	What are the top 5 challenges [insert country] is experiencing in service delivery? a. b. c. d. e.	

2.6.	Are there any policy barriers impacting service delivery? Yes No	
2.7.	If yes, please briefly describe the policy barriers impacting service delivery.	
2.8.	Based on your experience and expertise in FP, what would be the top 3 interventions/solutions to address the challenges expressed?	
3	**Demand Creation**	
3.1.	What demand creation High Impact Practices is your organization currently implementing: A. Community group engagement B. Digital technologies for social and behavior change C. Mass media	
3.2.	Which other areas in demand creation is your organization working to improve: A. Addressing social and gender norms B. Sensitization/mobilization of religious leaders and other leaders in the community C. Addressing provider bias D. Engaging men and boys in family planning E. Other: Indicate	
3.3.	Please provide a brief description of your work in Demand creation.	
3.4.	What is (was) the estimated budget and/or expenditures for these activities in the current calendar year _____? (***exclude indirect costs, salaries, and infrastructure) Currency_____Amount: _____	
3.5.	What are the top 5 challenges [insert country] is experiencing in acceptability and demand of FP services? a. b. c. d. e.	

3.6.	Are there any policy barriers impacting demand creation? Yes No	
3.7.	If yes, please briefly describe the policy barriers impacting demand creation.	
3.8.	Based on your experience and expertise in FP, what would be the top 3 interventions/solutions to address the challenges expressed?	
4	**Enabling Environment**	
4.1.	What enabling environment High Impact Practices is your organization currently implementing: A. Galvanize commitment to support FP programs B. Developing, implementing, and monitoring supportive government policies C. Domestic public financing for FP D. Supporting/developing effective supply chain management systems for FP E. Developing and supporting capacity to lead and manage FP programs F. Girls' education	
4.2.	Which other areas in enabling environment is your organization working to improve: A. Improving the availability, accessibility and use of Data for Decision-making B. Other: Indicate	
4.3.	Please provide a brief description of your work in Enabling environment.	
4.4.	What is (was) the estimated budget and/or expenditures for these activities in the current calendar year _____? (***exclude indirect costs, salaries, and infrastructure) Currency_____Amount: _____	
4.5.	What are the top 5 challenges [insert country] is experiencing in enabiling environment (policy, financing, stewardship, political will, data for decision-making etc.)? a. b. c. d. e.	

4.6.	Are there any policy barriers impacting an enabling environment for FP? Yes No	
4.7.	If yes, please briefly describe the policy barriers impacting enabling environment.	
4.8.	Based on your experience and expertise in FP, what would be the top 3 interventions/solutions to address the challenges expressed?	
5	**Commodity Security**	
5.1.	Which areas in commodity security is your organization working to improve: A. Forecasting and quantification B. Procurement C. Warehousing and Distribution D. Last Mile E. Logistics data and information system F. Method mix expansion G. Financing for commodity security H. Other: Indicate	
5.2.	Please provide a brief description of your work in Commodity security.	
5.3.	What is (was) the estimated budget and/or expenditures for these activities in the current calendar year _____? (***exclude indirect costs, salaries, and infrastructure) Currency_____Amount: _____	
5.4.	What are the top 5 challenges [insert country] is experiencing in commodity security? a. b. c. d. e.	
5.5.	Are there any policy barriers impacting commodity security for FP? Yes No	
5.6.	If yes, please briefly describe the policy barriers impacting commodity security.	

5.7.	Based on your experience and expertise in FP, what would be the top 3 interventions/solutions to address the challenges expressed?	
6	**Gender Equality**	
6.1.	Please provide a brief description of your work in gender equality.	
6.2.	What is (was) the estimated budget and/or expenditures for these activities in the current calendar year _____? (***exclude indirect costs, salaries, and infrastructure) Currency_____Amount: _____	
6.3.	What are the top 5 challenges [insert country] is experiencing in gender equality? a. b. c. d. e.	
6.4.	Are there any policy barriers impacting gender equality for FP? Yes No	
6.5.	If yes, please briefly describe the policy barriers impacting gender equality.	
6.6.	Based on your experience and expertise in FP, what would be the top 3 interventions/solutions to address the challenges expressed?	
7	**SRH – Young People**	
7.1.	Please provide a brief description of your work in the specified area.	
7.2.	What is (was) the estimated budget and/or expenditures for these activities in the current calendar year _____? (***exclude indirect costs, salaries, and infrastructure) Currency_____Amount: _____	
7.3.	What are the top 5 challenges [insert country] is experiencing in SRH-young people? a. b. c.	

	d. e.	
7.4.	Are there any policy barriers impacting SRH-young people for FP? Yes No	
7.5.	If yes, please briefly describe the policy barriers impacting SRH-young people.	
7.6.	Based on your experience and expertise in FP, what would be the top 3 interventions/solutions to address the challenges expressed?	
8	**Other Area**	
8.1.	Please provide a brief description of your work in the specified area.	
8.2.	What is (was) the estimated budget and/or expenditures for these activities in the current calendar year _____? (***exclude indirect costs, salaries, and infrastructure) Currency_____Amount: _____	
8.3.	What are the top 5 challenges [insert country] is experiencing in the specified area? a. b. c. d. e.	
8.4.	Are there any policy barriers impacting the specified area for FP? Yes No	
8.5.	If yes, please briefly describe the policy barriers impacting the specified area.	
8.6.	Based on your experience and expertise in FP, what would be the top 3 interventions/solutions to address the challenges expressed?	

APPENDIX 7

Example of an Issue-Solution Matrix

FP CIP Key Issues and Proposed Solutions

Last updated: _____

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

#	Item	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

APPENDIX 8

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 thematic 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 2**) 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 2 | 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

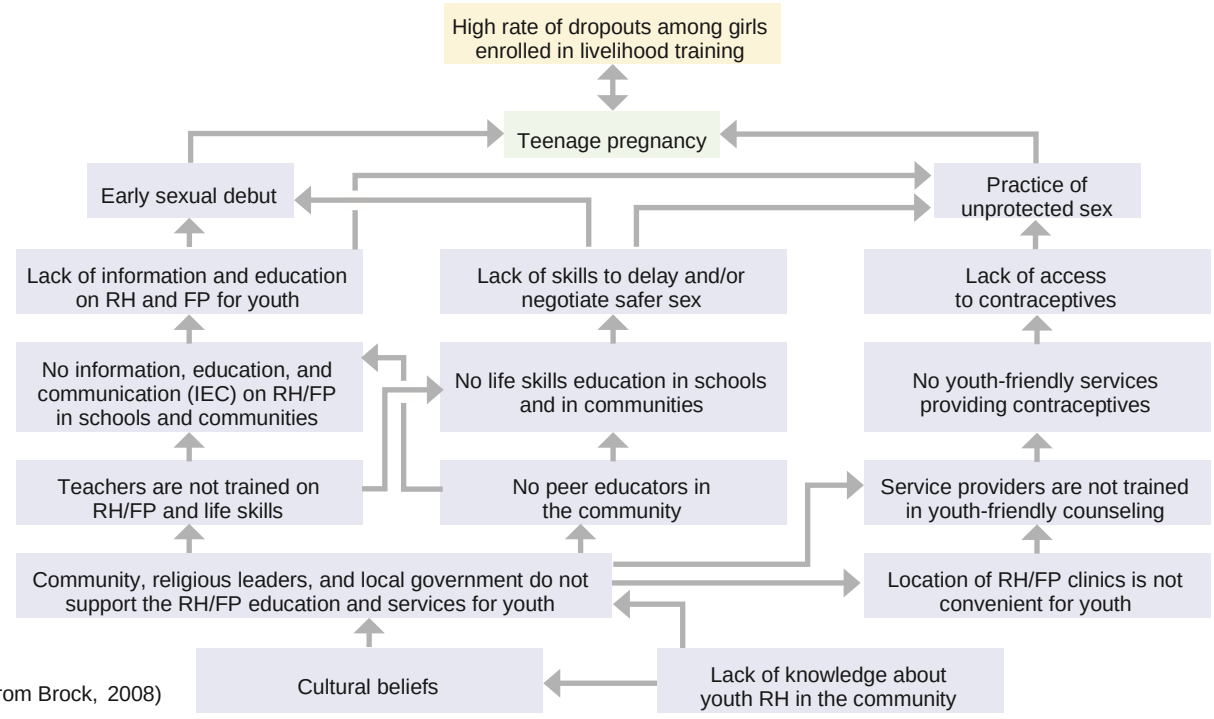
A problem tree analysis helps to map out the anatomy of cause and effect around an issue. This method is best conducted in a small group of about six to eight people, with a flip chart or post-it notes on a wall.

The TST works with stakeholders grouped around thematic 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 the situational analysis 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



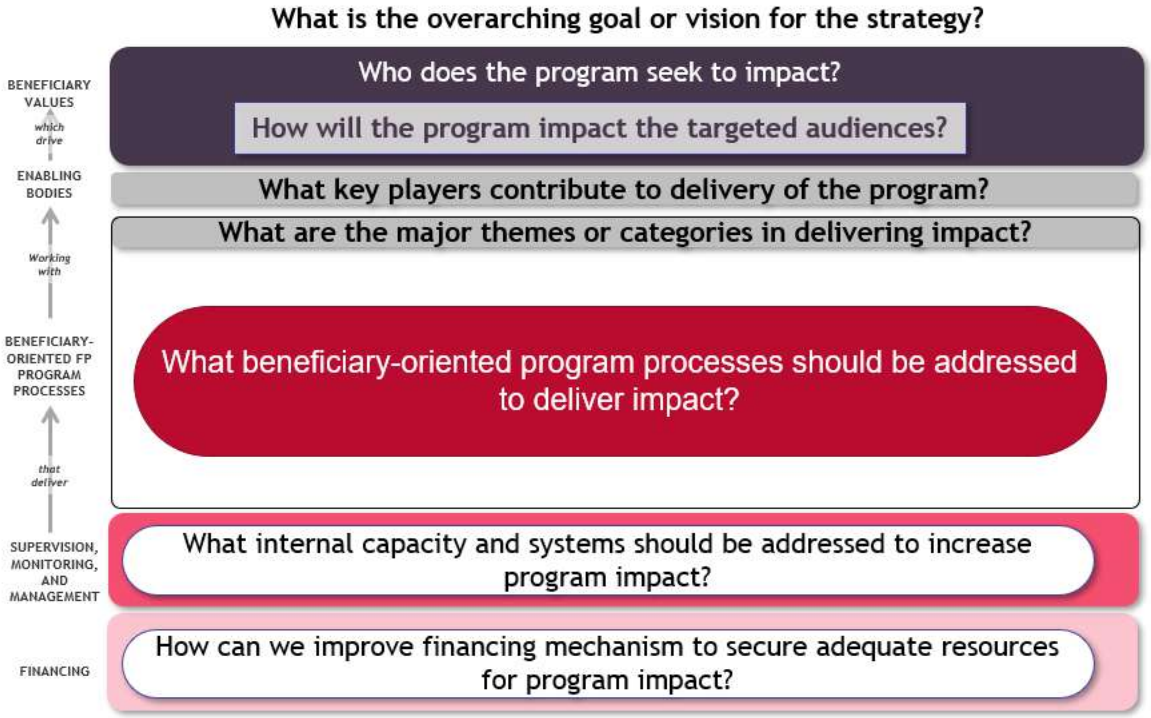
(adapted from Brock, 2008)

APPENDIX 9

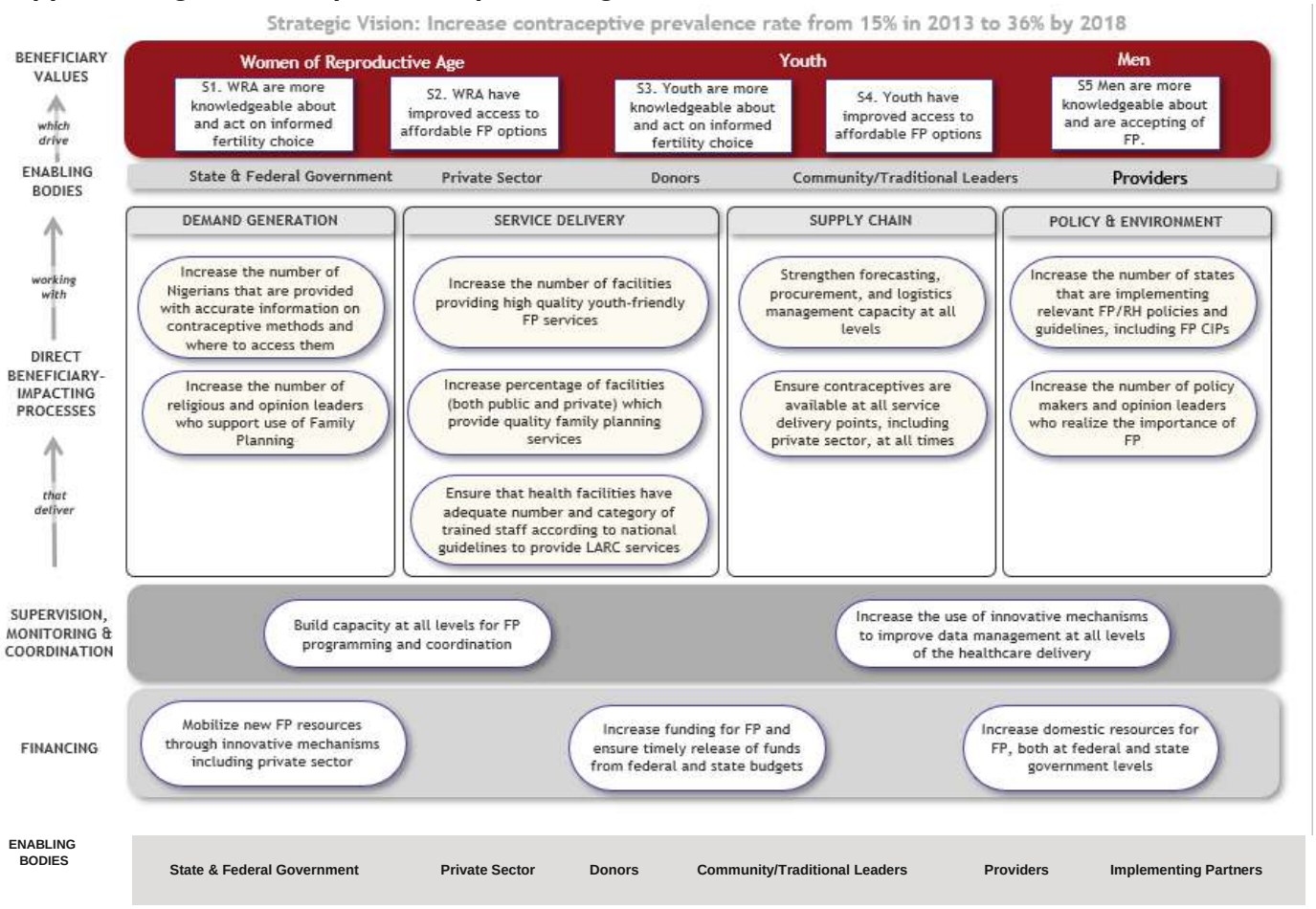
CIP Map Components and Example

A CIP map is a one-page graphical diagram that displays the strategic priorities, and how they work together across thematic areas to contribute to the achievement of the overall goal of the CIP. A CIP map differs from the results framework in that it only displays the strategic priorities, a subset of all the results included in the results framework. Strategic priorities should (1) address bottlenecks that were identified during problem analysis and/or (2) put in place enabling factors that accelerate achievement of the result in question. They 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.

Appendix Figure 2: CIP Map Components and Description



Appendix Figure 3: Sample CIP Map from Nigeria



APPENDIX 10

Setting an FP Goal

Setting goals is an important part of strategy development. Strategies may include multiple goals to guide progress, including Contraceptive Prevalence Rates (CPR), unmet need, and demand satisfied. Additionally, goals can cover different domains, such as equity, access to services, method availability, and financing; and may be set for both national and sub-national levels.

The most common topline goal included in CIPs and other FP strategies is Modern Contraceptive Prevalence (mCPR), which is easy to track across time and can be looked at in relation to contribution of specific contraceptive methods. While mCPR is a clear measurement goal, landing on the right number for an effective goal can be tricky. A right-sized goal is an important aspect of accountability; setting a goal too low or too high may impact motivation and limit the ability to hold the government accountable. An ambitious but achievable goal will generate momentum and political will, focus efforts, and serve as a benchmark for measuring progress.

Taking the time to set a good goal also allows for conversations about matching ambition to effort. If a country sets an ambitious goal, then their strategy must include activities and interventions that match that level of ambition. It is important to keep in mind that if achieving the new goal requires a shift in the current trend, a change in effort or approach will also be necessary to realize that goal. *Maintaining the status quo will not bend the curve.*

Be Clear!

Are you setting a goal for **married** or **all women**?

mCPR or **CPR**?

Also make sure to document any assumptions included in goal selection.

The guidance presented in this section is specific to setting mCPR goals, but many of the concepts and tools that are discussed can be applied to other goals as well.

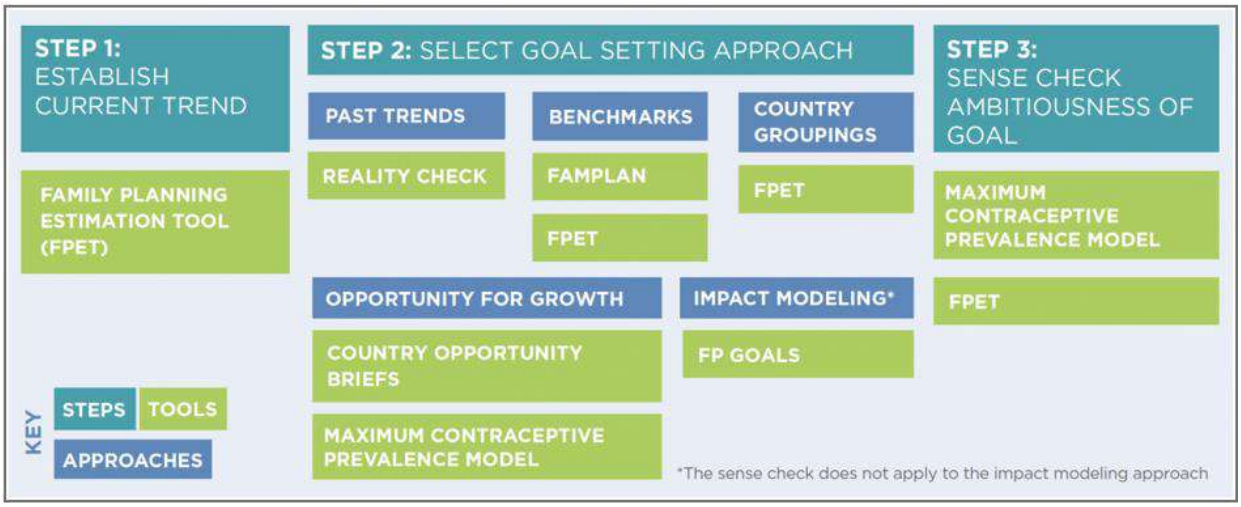
The Goal Setting Process

Choosing goals and setting targets for goals is both technical and political. Setting a goal for married women (MW) only signals who the FP program believes it should serve - this is a political decision. Goal values themselves can also be political or heavily influenced by the political – for example existing health strategies or national frameworks may have highly unrealistic goals for the program, but it may not be politically feasible to change these. Determining which data sources to use and to exclude can be both an issue of capacity and politics. Equally, determining who is consulted and engaged in goal and priority setting can be both a function of resources as well as a political decision.

There are several elements involved in setting a right-sized goal. All depend on leveraging the situational analysis on levels of performance, levels of “need” and degree to which existing strategies have been successful or not in achieving intended past goals. The situational analysis should also have information on what factors played a role in lack of success in current strategy using where possible secondary data analysis combined with expert opinion from implementers. There are readily available tools that would have been used during the situational analysis to establish the current trend, understand past trends, and opportunities for growth.

For a quick overview on the goal setting process and all of the approaches mentioned in this section, review the Goal Setting Overview Presentation.

Appendix Figure 4: Overview of Goal Setting Tools



The first step is to establish the current trend in mCPR. This should be completed in the situational analysis. This involves looking to the past to understand how mCPR has grown over time in your particular country context and making assumptions that will inform a best guess as to how the growth trend will continue in the future. The Family Planning Estimation Tool (FPET) is a web application that uses all available survey data to produce annual estimates for key FP indicators, such as contraceptive prevalence and unmet need for FP, and estimate trends into the future. The FPET online training module will provide you with detailed guidance on tool use and interpretation of results.

The second step is to review commonly used approaches to goal selection and select one to apply, taking into consideration your country context and the circumstances of your goal setting. The table above lists at least one tool for each approach listed in a purple box.

The third step is to do a **sense check** on the level of ambitiousness in the goal. There are two tools available to help with this step. The Maximum Contraceptive Prevalence Model estimates the highest level of mCPR that can be achieved in a country given its current situation in relation to fertility preferences and risk of pregnancy. The second tool, FPET, is the same tool mentioned in Step 1. In addition to estimating annual mCPR, FPET also calculates the probability of reaching different levels of mCPR. This can be used to determine if you are being too ambitious or not ambitious enough.

Setting Goals Based on Potential Future Growth

This Goal Setting: Past Trends, Benchmarks, and Country Groupings Presentation introduces three **tools** that are helpful when setting goals based on potential future growth: FPET, FamPlan and Reality Check.

A ***Past trends approach*** sets a goal based on observed historical trends in a country, which are extrapolated to a target level at some point in the future. The years used to create the trend vary, but oftentimes the trend between the last two national surveys is used. The target may be to maintain the trend as projected or adjust the trend upward.

Benchmarking sets a goal that aligns with something that is agreed upon by broad consensus. For example, it is commonly believed that a growth rate of 2 percentage points a year in CPR is fast growth, so a country may aspire to that rate as their goal.

Another example would be for a country to double their current growth rate. For example, if they are growing .5 points per year, their goal could be to grow at 1 point per year.

By using ***country groupings*****,** a goal may be set based on the average performance of similar countries. For countries that are growing slower than the group average, a goal of increasing to the average may be appropriate, while countries that are growing at the average rate or above may set a goal of increasing to the maximum growth in their category. Another grouping may be by where countries sit along the S-curve pattern of mCPR growth (low prevalence, growth, high prevalence stage).

Setting Goals Based on Opportunities for Growth

Another option for goal setting is to ***identify opportunities for mCPR growth*** and estimate the increase in mCPR that would be achieved if specific opportunities were met. This process starts by using data to identify large numbers of women of reproductive age with a need for FP. This approach is often used when priorities have already been set or data analysis shows that focus on a specific intervention or sub-set of women presents an opportunity for substantial growth in mCPR.

For example, in a country with a high Total Fertility Rate (TFR), you would look at the percent of postpartum women that are using FP. If there is a large percentage that are not using FP, a goal can be set that meets a segment of this population. You can also use data to identify specific barriers to uptake of FP. For example, if current levels of stockouts are inhibiting access to FP, you can set a goal of reducing stockouts by a certain percentage.

In many countries youth are already identified as a prioritized sub-group. You can use this approach to estimate the number of youth with an unmet need and then set a goal of reducing this unmet need by a specific amount. The impact of prioritizing these opportunities is estimated to establish an mCPR goal. These are just examples, there are other opportunities that can be quantified using this approach.

This presentation introduces three more tools: Opportunity Analysis, Injectable Model and MaxCPR Tool. These tools can identify opportunities for growth in mCPR through demand generation, increasing access to specific methods, reducing stockouts, or increasing access to specific populations such as adolescents and youth or postpartum women; determine the impact of scaling up injectables on mCPR; or estimate a country's highest potential contraceptive prevalence rate, both in terms of use for spacing and for limiting, based on an ideal number of children and key demographic life events.

Using Impact Modeling to Set Goals

This presentation provides more information on the *FP Goals Model*, a sophisticated strategic planning tool that estimates the impact of FP interventions on mCPR.

The *FP Goals Model* enables countries (or sub-national areas) to create scenarios that include implementation and scale-up of high impact practices, or HIPs (FP interventions that have been shown to increase contraceptive use and are documented in the literature). Different scenarios can be built selecting different interventions and different levels of coverage, for example, will a country get a larger impact on mCPR if postpartum FP (PPFP) or community-based distribution (CBD) is prioritized? These changes are then translated into an estimated change in mCPR. In addition to

setting an mCPR goal, the model also sets corresponding coverage goals for each selected intervention. The model uses country specific data so the results will differ based on the current FP situation and the structure of how FP services are currently provided. Additional guidance and links to the tools outlined in this appendix are available at http://www.track20.org/pages/monitoring/goal_setting.php.

APPENDIX 11

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

Impact	• Based on sound evidence of its effectiveness, is this output likely to bring about the desired change at scale? • What are the relative risks associated with exacerbation of the problem, if not addressed?
Feasibility	• What is the relative ease of implementation of the activities to implement the proposed result? • Is there technical, financial, and human capacity to implement the actions? • Is the cost of delivery realistic? • Do the FP stakeholders have direct influence over the attainment of the result, or does it require input from others? • Is this result likely to be sustainable in the long term? • What are the assumptions or prerequisites to achieving these results (for example, policy change)? • Can this be output be achieved during the CIP period? • Are there any legal, policy, or ethical concerns that may arise during implementation of activities to attain this result?

APPENDIX TABLE 4: Illustrative Prioritization Matrix

Score: 0 to 5

5 = High Impact

Score: 0 to 5

5 = High Feasibility

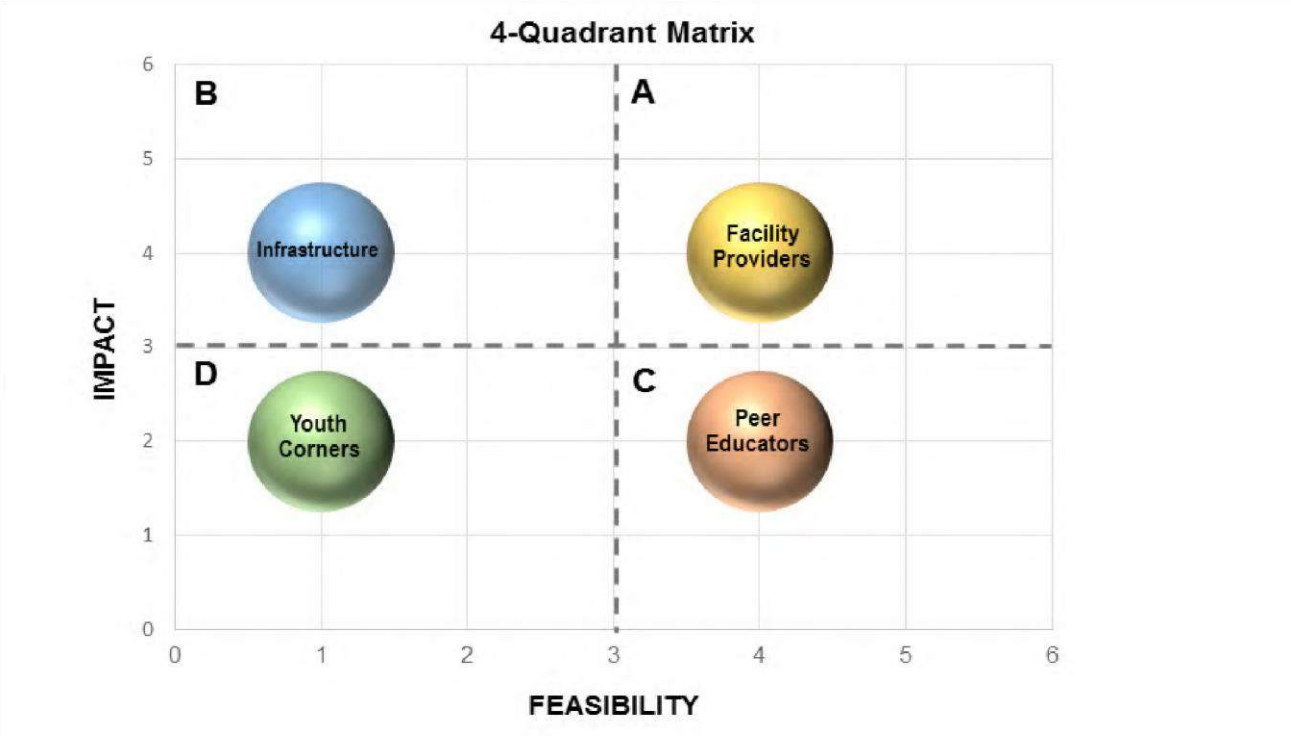
A = High Impact/High Feasibility
B = High Impact/Low Feasibility
C = Low Impact/High Feasibility
D= Low Impact/Low Feasibility

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**.



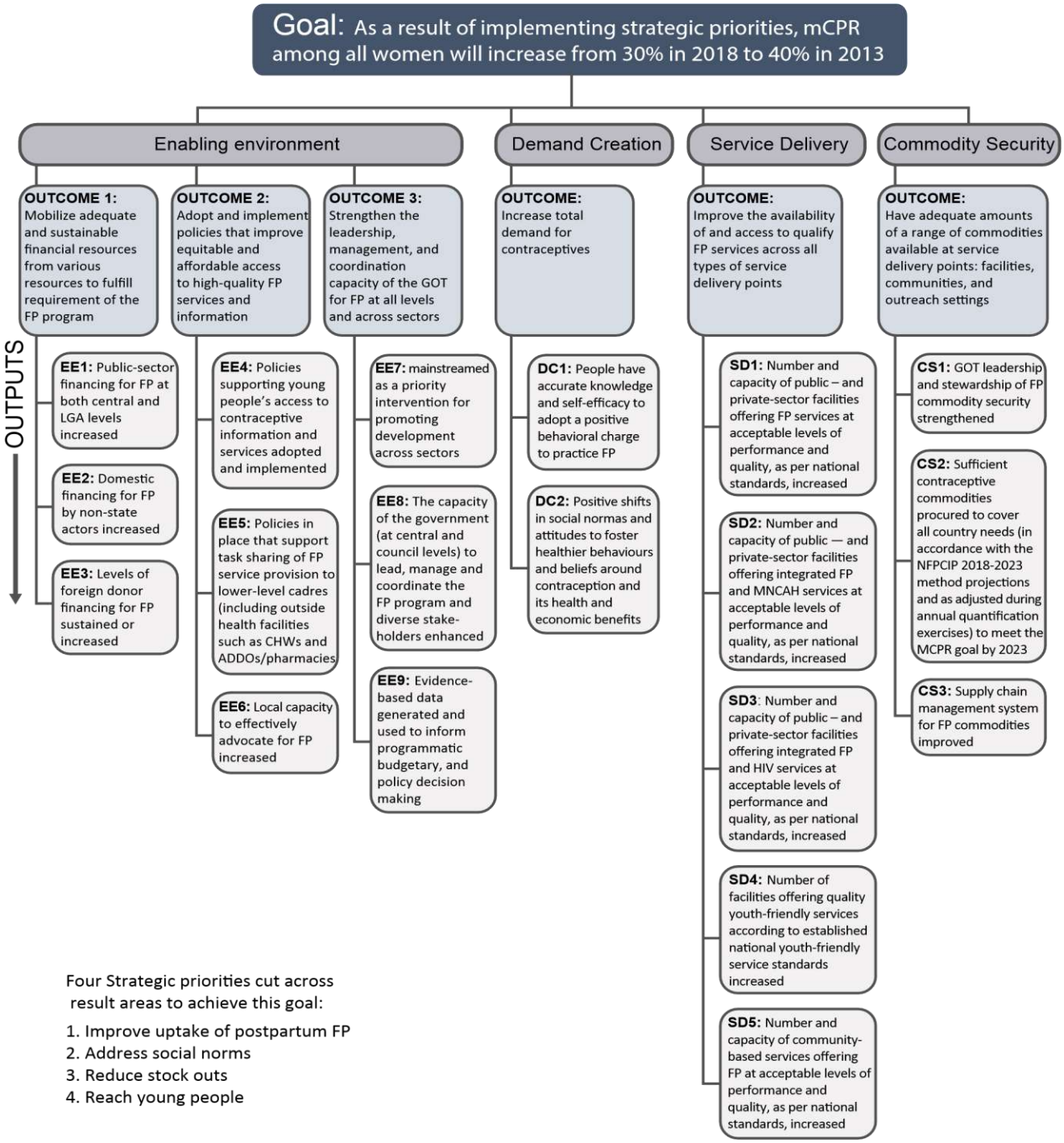
APPENDIX TABLE 5: Implications for Action, by Priority Level

Quadrant	Priority Level	Description	Implications
A	High	**High Impact/High Feasibility:** With high feasibility and high impact, these are the highest priority results and should be given sufficient resources to maintain and continuously improve.	• Assign high target estimates for costing because these should be implemented in high numbers.
B	Medium	**High Impact/Low Feasibility:** 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.	• 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 "*Hire new service providers*" 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). • Phase target estimates over a longer time, as change may not be expected in the near term.
C	Medium	**Low Impact/High Feasibility:** Often politically important and difficult to eliminate, these items may need to be re-designed to reduce investment while maintaining impact.	• Explore how best to increase impact or discuss alternative approaches. • Assign low-medium target estimates for costing. • Integrate with other results, if possible.

D	Low	**Low Impact/Low Feasibility:** 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.	• Consider dropping from list. • If keeping it on the list, carefully examine the potential value added to include in the plan, and consider having low costing targets.

APPENDIX 12

Results Framework from Tanzania National Family Planning CIP 2019-2023



Four Strategic priorities cut across result areas to achieve this goal:

1. Improve uptake of postpartum FP
2. Address social norms
3. Reduce stock outs
4. Reach young people

APPENDIX 13

Sample Indicators for Results Framework

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

Youth corners outside health facilities are established to serve as FP information hubs	Number of youth corners established	Program reports

APPENDIX 14

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
1) Coverage of youth-friendly services (YFS) at facility and community levels is increased								
Immediate Outcomes								
• 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				

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				
2) Young people (10-24 years of age) are knowledgeable about FP								
Immediate Outcomes								
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 Number/ percentage of adolescents served or reached by the program
		Engage a research consultant to help understand why the current messaging is not resonating with certain groups of people	X					
		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 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

APPENDIX 15

Costing for Two-Year Implementation Plans

CIP costing covers two components: (1) the cost of commodities needed to reach the CIP goal, and (2) the cost of programmatic costs associated with implementation. More information about Costing can be found under **Step 5**.

Approaches to commodity costing

Commodity costing should be linked to the forecasting of commodity requirements done as part of results formation. Tools such as the CIP Costing Tool, Reality √ , Spectrum's FamPlan Module, Impact 2, Impact Now, CastCost, and PipeLine can be used to forecast commodity requirements. Unit costs per commodity should then be applied to these forecasts to generate commodity cost estimates.

Approaches to programmatic costing

The CIP Costing Tool uses an ingredients-based costing approach to estimate resource requirements associated with implementing the activities outlined for each individual year of the implementation plan. The tool was set up to provide detailed annual costs and a total cost for 5 years, so if a 5-year detailed implementation plan is developed, this tool can be used to develop a full five-year cost estimate. However, in cases where only a two-year implementation plan is developed, the CIP Costing Tool cannot be used to generate a cost estimate for the 5-year period because it will only have detailed inputs for two years of activities. While 2-year cost estimates may be sufficient for some countries, other countries may want cost estimates for the entire five years of the plan. Some potential options for the remaining years include:

- Only include programmatic costing for the first two years, and develop cost estimates for subsequent years as new implementation plans are developed
- Use the costs generated for the first two years to estimate costs in subsequent years by determining, for each output or activity, the expected level of costs in future years as compared to costs in the first two years and use this to project forward costs accordingly:
    - Similar: activities require a similar level of effort each year
    - Higher: activities will be scaled up over future years and therefore costs will increase
    - Lower: activities are more intensive in the first two years due to start up investments that will not be maintained
- Use costs generated for the first two years to calculate an average programmatic unit cost (e.g., per facility, CHW, district, state) for the first two years and use that to extrapolate costs for the remaining years based on CIP goals and targets. Given that programmatic costs covered by the CIP are often unrelated to the direct number of beneficiaries reached (as they account for things like meetings, trainings, material development) using a per user approach is not recommended.
- Intervention-based costing approach can be used to generate costs linked to CIP outcome targets for multiple years as defined by the country. However, intervention costing includes costs that are not typically included in the CIP, for instance the cost of labor. The CIP includes incremental costs over and above what the government is routinely funding; most commonly, these include the cost of labor and infrastructure. In essence, the CIP only includes

incremental direct costs of implementing an intervention. It is important to consider what types of costs inputs are included to ensure transparency and comparability.