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

PPFP Country Programming Strategies Worksheet

I. Introduction to the Postpartum Family Planning (PPFP) Country Action Plan

The Postpartum Family Planning (PPFP) Country Programming Strategies Worksheet is an action-driven complement to the resource, *Programming Strategies for Postpartum Family Planning.*

The tool aims to guide country teams of maternal, child and reproductive health policymakers, program managers and champions of family planning in systematically planning country-specific, evidence-based "PPFP Programming Strategies" that can address short interpregnancy intervals and postpartum unmet need and increase postpartum women's access to family planning services. During the meeting, country teams will work together, with an embedded facilitator, on the following activities:

(1) Identify all existing PPFP programs that are already being implemented.

(2) Assess if there are other opportunities/entry points for providing family planning services to women during their postpartum period.

(3) Evaluate those programs in light of a country-level PPFP situational analysis and a health systems Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis to determine whether the same programs, or new or modified programs, should be adopted as the country's future PPFP programs.

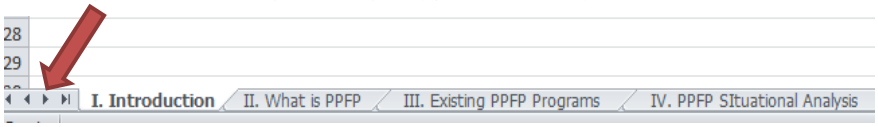
(4) For each of the future PPFP programs, complete a detailed PPFP Implementation Plan and consider how each program can best be scaled up to reach national and global family planning goals.

(5) Create a PPFP Action Plan to document the tasks required and team members responsible for adoption of the PPFP Implementation Plans by relevant decision-makers. The PPFP Action Plan will be revisited and revised during each future meeting of the country team until the PPFP Implementation Plan has been adopted.

Instructions:

1. Please only fill in the cells that are highlighted in yellow.

2. There are 9 separate tabs to assist you in completing your PPFP strategies. To scroll to the next sheet left click on this arrow:



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II. What is PPFP?

PPFP is "the prevention of unintended pregnancy and closely spaced pregnancies through the first 12 months following childbirth," but it can also apply to an "extended" postpartum period up to two years following childbirth. PPFP increases family planning use by reaching couples with family planning methods and messages around and after the time of birth and saves lives by promoting healthy timing and spacing of pregnancies, which is associated with decreased maternal, infant and child mortality. Because women are typically less mobile at least in the early part of the first year postpartum, PPFP programs can benefit greatly from integrating services in both community- and facility-based settings. Such programs must, however, be carefully adapted to the maternal, newborn and child health (MNCH) continuum of care that exists within a given country's health system to foster adoption, implementation and scale-up.

Figure 1. Contact Points for PPFP during the Extended Postpartum Period [WHO 2013]

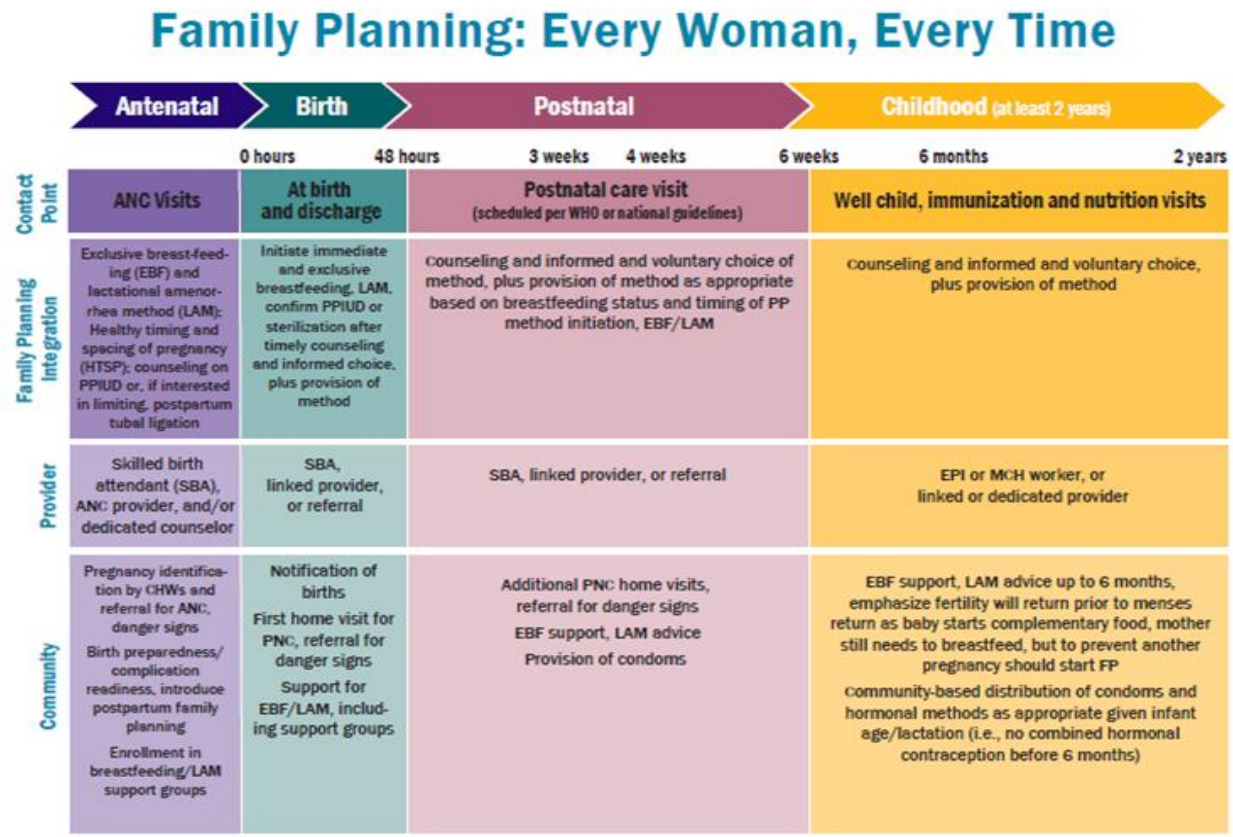
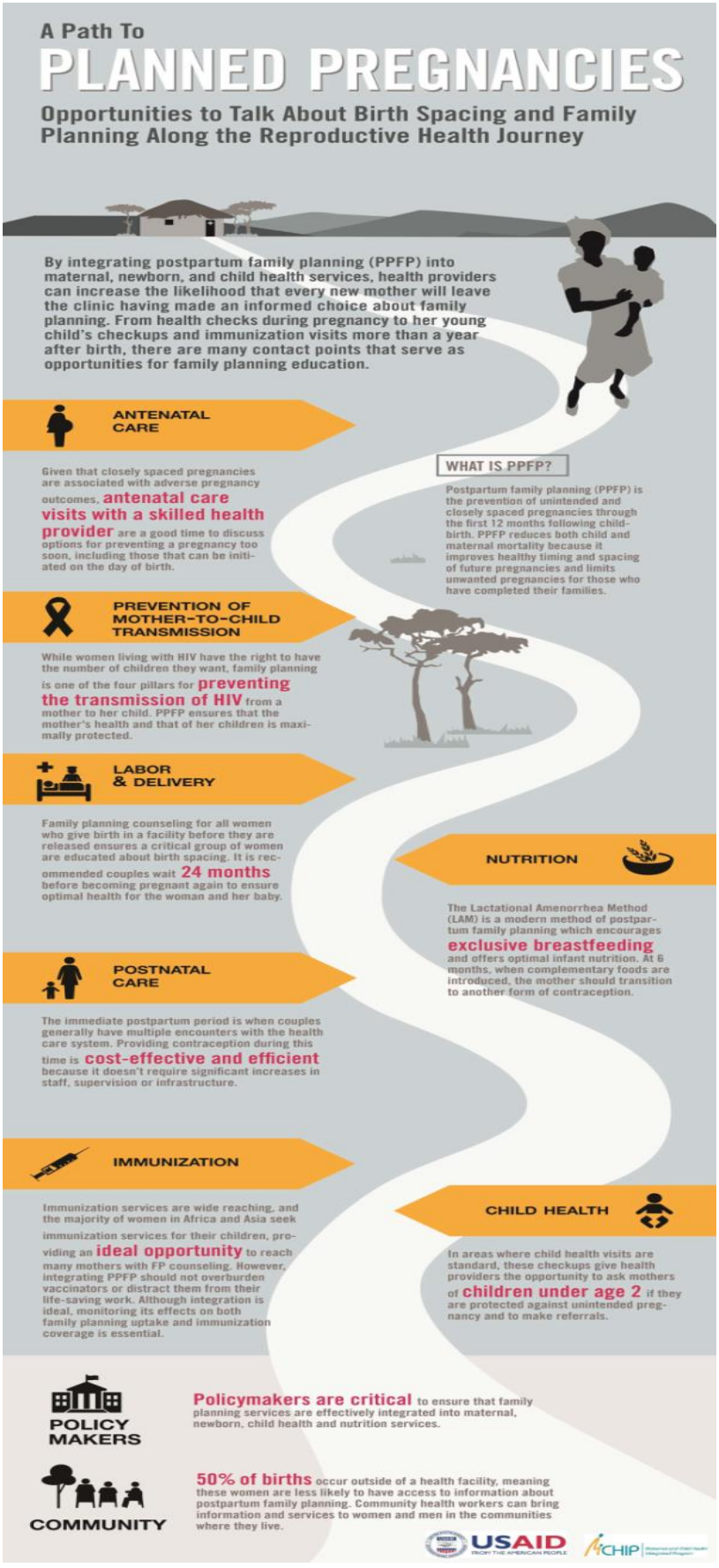


Figure 2. PPFP Integration Opportunities [MCHIP 2013]



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PPFP Country Programming Strategies Worksheet

Country:	Zambia	Country Coordinator:	Dr. Angel Mwiche

III. Existing PPFP Programs

Consider the figures above and review Chapter 3 in *Programming Strategies for Postpartum Family Planning* to determine which PPFP programs already exist in your country. Discuss as many programs as possible with your country team, but list the most promising three programs in the table below and explain the specific activities that have been undertaken to implement each one. Note the key stakeholders (policymakers, program managers, providers, nongovernmental organizations, beneficiaries) who have supported each activity and the organizations that have been involved in implementation. Identify any indicators being used to evaluate whether the program's goals are being achieved.

Existing PPFP Program 1:	**Strengthen awareness of and demand for PPFP during the ANC period**
Activity 1:	**Integrate PPFP information and counselling with ANC and PMTCT services offered at facility and community levels**
Timeframe	**3 years**
Evidence of success	**Insufficient data**
Total cost over timeframe	**To consult some Stake holders**
Has this activity been scaled? Why or why not?	**Yes, It is cost effective, leveraging resources to reach more people, It is a Best Practice**
Key stakeholders	**MoH, MCDMCH, PSI, MSZ, Jhpiego/Zambia, ZERHP/SUFP, FHI360, PPAZ , UNFPA, MDGi, CHAI, CHAZ**
Implementing agency(ies)	**USG, DFID, SIDA, EU, WHO, BMGF, Dutch Government**
Activity 2:	**Promote the inclusion of husbands and other family members in ANC education and counselling**
Timeframe	**3 years**
Evidence of success	**Insufficient data**
Total cost over timeframe	**To consult some Stake holders**
Has this activity been scaled? Why or why not?	**Yes, Reproductive health messages become very effective with partner involvement**
Key stakeholders	**MoH, MCDMCH, PSI, MSZ, Jhpiego/Zambia, ZERHP/SUFP, FHI360, PPAZ , UNFPA, MDGi, CHAI, CHAZ**
Implementing agency(ies)	**USG, DFID, SIDA, EU, WHO, BMGF, Dutch Government**
Activity 3:	
Timeframe	
Evidence of success	
Total cost over timeframe	

Has this activity been scaled? Why or why not?	
Key stakeholders	
Implementing agency(ies)	
Indicator(s) (Data Source):	No data available
Existing PPFP Program 2:	**Strengthen Continiuity of care linkages and referrals between facility and community and ANC and Birthing services**
Activity 1:	**Referral Linkages developed or strengthened between ANC services and labour & delivery services, whether they are located in in the same place or in different facilities/settings**
Timeframe	**3 Years**
Evidence of success	**Insufficient data**
Total cost over timeframe	**To consult some Stake holders**
Has this activity been scaled? Why or why not?	**No, tracking system not in place**
Key stakeholders	**MoH, MCDMCH, PSI, MSZ, Jhpiego/Zambia, ZERHP/SUFP, FHI360, PPAZ , UNFPA, MDGi, CHAI, CHAZ**
Implementing agency(ies)	**USG, DFID, SIDA, EU, WHO, BMGF, Dutch Government**
Activity 2:	**For women living with HIV, ensure there is linkage to FP services during HIV services for infant care and continued HIV treatment for the mother**
Timeframe	**3 years**
Evidence of success	**Insufficient data**
Total cost over timeframe	**To consult some Stake holders**
Has this activity been scaled? Why or why not?	**Yes, comprehensive tracking system not in place**
Key stakeholders	**MoH, MCDMCH, PSI, MSZ, Jhpiego/Zambia, ZERHP/SUFP, FHI360, PPAZ , UNFPA, MDGi, CHAI, CHAZ**
Implementing agency(ies)	**USG, DFID, SIDA, EU, WHO, BMGF, Dutch Government**
Activity 3:	
Timeframe	
Evidence of success	
Total cost over timeframe	
Has this activity been scaled? Why or why not?	
Key stakeholders	

Implementing agency(ies)	
Indicator(s) (Data Source):	
Existing PPFP Program 3:	**SDPs provide PNC including PPFP information, Counseling and Services**
Activity 1:	**At the time of the 6-week postpartum checkup, women are provided PPFP information and counselling, and are offered appropriate methods depending on their breastfeeding status**
Timeframe	**Ongoing**
Evidence of success	**Proportion of facilities offering at least three FP methods plus LAM**
Total cost over timeframe	**To consult some Stake holders**
Has this activity been scaled? Why or why not?	**Yes, to timely identify post delivery complications both to the mother and baby and manage them and initiate family planning**
Key stakeholders	**MoH, MCDMCH, MSZ, ZHERP/SUFP,PSI, Jhpiego/Zambia**
Implementing agency(ies)	**USG, DFID, EU, WHO, BMGF, Dutch Government**
Activity 2:	**PNC providers are trained and competent to counsel and provide appropriate methods for breastfeeding and non breast feeding women and for women with medical conditions that limit which options can be provided**
Timeframe	**Ongoing**
Evidence of success	**Proportion of SDPs that have at least one PNC or PMTCT provider trained in PPFP counselling and method provision**
Total cost over timeframe	**To consult some Stake holders**
Has this activity been scaled? Why or why not?	**Yes, because it provides more opportunities for women to receive PPFP**
Key stakeholders	**MoH, MCDMCH, MSZ, ZHERP/SUFP,PSI, Jhpiego/Zambia**
Implementing agency(ies)	**USG, DFID, EU, WHO, BMGF, Dutch Government**
Activity 3:	
Timeframe	
Evidence of success	
Total cost over timeframe	
Has this activity been scaled? Why or why not?	
Key stakeholders	
Implementing agency(ies)	
Indicator(s) (Data Source):	No National data available

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PPFP Country Programming Strategies Worksheet

Country:	Zambia	Country Coordinator:	Dr. Angel Mwiche

IV. PPFP Situational Analysis

Successful PPFP programs align with the demographic characteristics of the postpartum population within a country and are adapted to the country's governance context. The following table extracts the demographic and family planning governance data that should influence program plans. Fill in the data response that your country team agrees upon and provide the source used if is different from or more specific than the one listed. ***See Tab IX for select suggested data responses.***

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
DEMOGRAPHIC DATA				
1	Total population (as of mid-2014)	Population Reference Bureau (see Tab IX)	15,111.00	Population that will benefit from families reaching desired size
2	Annual population growth, %	Population Reference Bureau "Rate of Natural Increase" (see Tab IX)	3.40%	Pace of population change that could be slowed with PPFP
3	Crude birth rate	Population Reference Bureau (see Tab IX)	45	Numbers of births occurring
4	Number of women of reproductive age (WRA)	Population Reference Bureau (see Tab IX)	3,300,000	Population with future potential to need PPFP to reach desired family size and reduce maternal and child health risks
5	Number of WRA who are pregnant	Calculated from Population Reference Bureau (see Tab IX)	679,995	Population with immediate potential to need PPFP to reach desired family size and reduce maternal and child health risks
6	Total fertility rate	Demographic and Health Survey (see Tab IX)	5.3	Number of births per woman with opportunity for PPFP—compare with #7 on ideal family size
7	Ideal family size	Demographic and Health Survey (see Tab IX)	5	Compare with #6 on total fertility rate
8	Adolescent fertility rate	Population Reference Bureau (see Tab IX)	138	Number of births per girl ages 15–19 with opportunity for PPFP (Also consider what proportion of this are births to girls <18 as those with highest maternal mortality risk.)

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
9	Percentage of birth-to-next-pregnancy (interpregnancy) interval of: ➢ 7–17 months ➢ 18–23 months ➢ 24–35 months ➢ 36–47 months	Demographic and Health Survey (see Tab IX)	5 10 40 24	Optimal birth-to-pregnancy (interpregnancy) intervals are 24 months or longer, so those 23 months or less are too short and are riskiest for mother and child (Consider lack of awareness of this risk or access to family planning among postpartum WRA.)
10	Percentage of first births in women: ➢ 15–19 years old ➢ 20–23 years old ➢ 24–29 years old ➢ 30–34 years old	Demographic and Health Survey (see Tab IX)	2 19.1 19.2 19	Population of first-time parents who can receive PPFP early and often as they reach desired family size
11	Percentage of unmet need among WRA	Demographic and Health Survey (see Tab IX)	26.6	Population of women who do not want to become pregnant and who are not using family planning—levels above 10% suggest low effectiveness of family planning efforts
12	Percentage of unmet need for: ➢ spacing ➢ limiting	Demographic and Health Survey (see Tab IX)	15.9 11	Distinguishes women with unmet need who wish to have children in the future ("spacers") from those who wish to avoid future pregnancies ("limiters")—levels should be compared with method mix in #16 to determine whether reaching women with the right method at the right time
13	Percentage of postpartum prospective unmet need	Z. Moore et al., Contraception 2015	34	Population of women who *currently* need PPFP to reach desired family size and reduce maternal and child health risks
14	Contraceptive prevalence rate	Demographic and Health Survey (see Tab IX)	49	Population of women who are currently using family planning
15	Your country's CPR target	Government website or other publicly available reference	58	Population of women who are expected to use family planning (postpartum or otherwise) by a certain date—consider gap from #14

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
16	Contraceptive prevalence rate for: ➢ Short-acting contraception ➢ Long-acting, reversible contraception (LARC) ➢ Lactational amenorrhea method (LAM) ➢ Permanent contraception	Demographic and Health Survey (see Tab IX)	30.40% 0.50% 13.6% 1.9%	Current method mix, especially interest in contrasting use of permanent methods against #12, unmet need for limiting, and the more effective yet reversible LARCs, and potential for transition from LAM to other methods such as LARCs to reach desired family size and reduce maternal and child health risks (Also consider coverall method mix, e.g., the number of methods that are used by >20% of family planning users.)
17	Percentage of women who receive at least one antenatal care visit	Demographic and Health Survey (see Tab IX)	96	Population that can be reached with PPFP messages early in the MNCH continuum of care and receive service after delivery with systematic implementation
18	Percentage of women practicing exclusive breastfeeding (EBF) at: ➢ 2 months ➢ 5–6 months	Demographic and Health Survey (see Tab IX)	75.3 25.4	Consider whether a family planning strategy promoting LAM (i.e., 6 months of EBF before return of menses) could potentially increase duration of EBF and produce child and maternal health benefits beyond birth spacing.
19	Percentage of deliveries in health facilities	Demographic and Health Survey (see Tab IX)	67	Population that can be reached with PPFP methods on the "day of birth," including LARCs—can be broken down by age, residence and wealth quintiles to highlight underserved groups.
20	Percentage of deliveries at home	Demographic and Health Survey (see Tab IX)	31	Population that can be reached with community-based promotion of PPFP—can be broken down by age, residence and wealth quintiles to highlight underserved groups.
21	Percentage of women who receive at least one postnatal care visit	Possibly Demographic and Health Survey; if not, use other available data or estimations	28.3	Population that can be reached after birth with PPFP counseling and services other than at routine immunization visits
22	Percentage of women who receive a postnatal care visit at: ➢ 0–23 hours ➢ 1–2 days ➢ 3–6 days ➢ 7–41 days ➢ 42 days (6 weeks)	Possibly Demographic and Health Survey; if not, use other available data or estimations	48 2 2.2 2.5 -	Population that can be reached with certain PPFP methods that are available in the immediate postpartum period (i.e., prior to discharge) or that need to be introduced at later contact points

	Data Point	Potential Sources/Formula	Data Response	PPFP Implications
23	Immunization rates for: ➢ Birth BCG ➢ DPT1 ➢ DPT3 ➢ Drop-out rate between DPT1 & DPT3	Demographic and Health Survey (see Tab IX)	94 94.8 82.4 12.4	Population that can be reached with PPFP methods at routine immunization visits or through referrals from these visits
24	OPTIONAL: Percentage of women who experience violence during pregnancy, childbirth or for using family planning	Possibly Demographic and Health Survey; if not, use other available data or estimations		Importance of sensitizing health workers to this population, including possible reproductive coercion and preparing them to sensitively discuss gender-based violence mitigation or prevention strategies integrated with PNC/PPFP services. Also role of discreet/clandestine methods for these women.
25	Percentage of unsafe abortions	WHO, Unsafe Abortion, 2008 http://whqlibdoc.who.int/publications/2011/9789241501118_eng.pdf?ua=1 [regional estimates only]	30	Population that is at high maternal mortality risk and is likely to need postabortion care, including FP services
GOVERNANCE DATA				
26	FP2020 Commitment	http://www.familyplanning2020.org/reaching-the-goal/commitments	National FP Scale up plan 2013-2020 is being Implemented.	Country-level, public financial commitment to invest in FP
27	Statement for Collective Action for PPFP Country Endorsement	http://www.mchip.net/actionppfp/	On going consultations	Country-level, public support/champions for PPFP
28	National FP Strategy	Government website or other publicly available citation	National FP Scale up plan 2013-2020 is being Implemented.	Where PPFP should be included or enhanced to affect national policy
29	FP Costed Implementation Plan	Government website or other publicly available citation	National FP Scale up plan 2013-2020 is being Implemented.	Where PPFP programs with budgets should be included or enhanced to affect national policy
30	Provide PPFP Implication for: "Provider cadres that are authorized to deliver PPFP services"	http://www.optimizemnh.org/intervention.php	Inadequate providers of FP	

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PPFP Country Programming Strategies Worksheet

Country:	Zambia	Country	Dr. Angel Mwiche

V. Health Systems "SWOT" Analysis

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

Existing PPFP Program 1:	**Strengthen awareness of and demand for PPFP during the ANC period**

	Health System Dimension	**Strenths**	**Weaknesses**	**Opportunities**	**Threats**
I	Health Services				
	a. Public sector	Trained Staff	Shortage of staff trained in LARC and weak referral systems	scale up LARC in pre-service training	Capacity to go to scale and increased coverage due to shortage of staff
		Political will	Infrastructure	Availability of media Houses	Legal framework and policy environment not always adequate to initiate or sustain change
		Strategic Plan in Place	Operationalizing	Availability of traditional leaders who are FP Champions	Myths and misconceptions
	b. Faith-based/non-governmental organization (NGO)	Availability of conducive Infrastructure	Some religious practices prevent access to family planning	Support from the Government	Donor Dependance
		Motivated workforce	Weak integration into the national health system for some organisations	Strong PPP in place	Change in Policy is very slow
		Independent funding system	Lack of transparency of how funding is used to support the programme	Leveraging resources for increased services	Program tied to implementing NGO
	c. Private sector	Good infrastructure	Weak linkages with Government	Support from Government	Competions for better services
		Generate own income	Temporal Human Resource	Availabilty of insurance schemes and choice	Change of Government & Political Leadership
			Unaffordable services		

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
2	Health management information system (HMIS)	The HMIS is in place	Indicators not dissagregated, reviewing and updating indicators takes very long	Support from partners	Multiple data collection tools by Partners
3	Health workforce	Different Cadres trained in FP	High attrition	Supported by various training Institutions and partners	Limited funds to support more human resource
4	Medicines and technology	Decentarlized distribution points	Inefficient Supply Chain	Partner Support	Some FP commodities are partner dependant
5	Health financing	8 year FP costed plan, budgeted activities for capacity building by government and partners	inadequate fundig for FP, limited partners providing PPFP	Chance to scale up to other districts	Competing needs for other FP activities
6	Leadership and governance	Central FP TWG in place, a good platform to implement FP programs in districts	Weak FP TWG at provincial and district level, inadequate linkages between labour ward and FP units in most of the facilities	Availabilty of health care providers to be trained in PPFP and a very high unmet need.	Political, religious, cultural and traditional myths and misconceptions for PPFP
7	Community and sociocultural				
	a. Community-based	Availability of CBDs, SMAGs, CHWs	Shortage of POP and indaquate information on PPFP	High unmet need for FP	High attrition rate due to lack of motivation
		Sentised opinion leaders in communities eg FP champions	Lack of infrastructure for the provision of PPFP	High demand for FP	Not fully integrated in the health care system
		Favourable interaction between the community, CHWs and HCP	Inadequate skills as well as long distances to reach health centres	FP links to socio-economic status of individual families	Disparity of information and skills
	b. Mobile outreach	Multiple contact able to address multiple health issues	Inadequate infrastructure to provide PPFP	Alternative non traditional service delivery structures eg tents, mobile hospitals	Unable to capture special groups such as adolescents and the disabled
		Leveraging resources to do many health activities	Inadequate logistics and trained staff	Engagement of communities to leverage resources	High cost of doing out reach
		Provision of access in under served communities	low acceptance of the service	Support community champions to conduct more FP sensitisations	Poor road network/ seasonal challenges

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
7	c. Social marketing	Availability of FP socially marketed products such as Ocs	Limited access to distribution in some areas	good marketing environment	Donor dependancy
		Easy access to socially marketed products	No consumer contact/ no data on use and acceptability	Larger target audience	Inferior and unfamiliar products
		Multiple channels for social marketing including CBDs, drug stores, pharmacies.	No follow up in case of misuse or failures	High unmet need for FP	Unregulated products on the market
Existing PPFP Program 2:		**Strengthen Continiuity of care linkages and referrals between facility and community and ANC and Birthing services**			
Health System Dimension		**Strenths**	**Weaknesses**	**Opportunities**	**Threats**
1	Health Services				
	a. Public sector	Trained Staff	Shortage of staff trained in LARC and poor tracking and follow up	Revise and update the guidelines and the indicators tracking PPFP	Long distances between facilities and poor road network
		The policy and guidelines are available and standardized	Inadequate space for integrated service delivery	Improve mapping of areas that need more training	Resistance to changing long standing traditional practices
		Referal system already exists between the different levels of the health system	Shortages in appropriate equipment to insure referred clients are attended to	Stronger coordination of partner support	Myths and misconceptions about FP after delivery
	b. Faith-based/NGO	Availability of conducive Infrastructure	Some religious practices prevent access to family planning	Support from the Government	Donor Dependance, inconsistency in funding levels
		Motivated workforce	Weak integration into the national health system for some organisations	Strong PPP in place	Change in policy is very slow as well as the legal framework governing task shifting of some FP services
		Independent funding system	Lack of transparency of how funding is used to support the programme	Leveraging resources for increased services	Program tied to implementing NGO
	c. Private sector	Good infrastructure and other resources	Weak linkages with Government	Support from Government	Referals are only done for critical cases to public sector facilities
		Generate own income	Temporal Human Resource	Availabilty of insurance schemes and choice	No policy framework that supervises private sector providers

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
1	c. Private sector	Reduced bureaucratic processes	Clinical quality varies and is based on profit margins with high turnover of staff	Can help decongest public sector clinics through more inclusion as FP providers	
2	HMIS	The HMIS is in place	Indicators not dissagregated, reviewing and updating indicators takes very long	Support from partners	Multiple data collection tools by Partners
3	Health workforce	Different Cadres trained in FP	High attrition	Supported by various training Institutions and partners	Limited funds to support more human resource
4	Medicines and technology	Decentarlized distribution points	Occasional stocks out of commodities in the supply Chain	Partner Support	Procurement of FP commodities are partner dependant
5	Health financing	8 year FP costed plan, budgeted activities for capacity building by government and partners	inadequate fundig for FP, limited partners providing PPFP	Chance to scale up to other districts	Competing needs for other FP activities
6	Leadership and governance	Central FP TWG in place, a good platform to implement FP programs in districts	Weak FP TWG at provincial and district level, inadequate linkages between labour ward and FP units in most of the facilities	Availabilty of health care providers to be trained in PPFP and a very high unmet need.	Political, religious, cultural and traditional myths and misconceptions for PPFP
7	Community and Sociocultural				
	a. Community-based	Availability of CBDs, SMAGs, CHWs	Logistical challenges of referring from community to facility;	High unmet need for FP	High attrition rate due to lack of motivation
		Sentised opinion leaders in communities eg FP champions	Not all facilities are adequately equipped to manage referred clients	High demand for FP	Not fully integrated in the health care system
		Favourable interaction between the community, CHWs and HCP	Inadequate skills as well as long distances to reach health centres	FP links to socio-economic status of individual families	Disparity of information and skills
	b. Mobile outreach	Multiple contact able to address multiple health issues	Inadequate infrastructure to provide PPFP	Alternative non traditional service delivery structures eg tents, mobile hospitals	Unable to capture special groups such as adolescents and the disabled
		Leveraging resources to do many health activities	Inadequate logistics and trained staff	Engagement of communities to leverage resources	High cost of doing out reach
		Provision of access in under served communities	low acceptance of the service and low follow up of clients	Support community champions to conduct more FP sensitisations	Poor road network/ seasonal challenges

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
7	c. Social marketing	Availability of FP socially marketed products such as Ocs	Referrals are not done	good marketing environment	Donor dependancy
		Easy access to socially marketed products	No support system for adverse events and management of clients	Larger target audience	Inferior and unfamiliar products
		Multiple channels for social marketing including CBDs, drug stores, pharmacies.	No folllow up of clients	High unmet need for FP	Unregulated products on the market
Existing PPFP Program 3:		**SDPs provide PNC including PPFP information, Counseling and Services**			
Health System Dimension		**Strenths**	**Weaknesses**	**Opportunities**	**Threats**
1	Health Services				
	a. Public sector	Trained Staff	High attrition of trained Human resource	Scale up LARC in pre-service training	Capacity to go to scale and increased coverage due to shortage of Human Resource
		Political will	Infrastructure	Availability of media Houses	Legal framework and policy environment not always adequate to initiate or sustain change
		Available Guidelines and protocols	Inadequate tracking system	Advocacy for Integration of SRH/FP services	Myths and misconceptions
	b. Faith-based/NGO	Availability of conducive Infrastructure	Some religious practices prevent access to family planning	Support from the Government	Donor Dependance
		Motivated workforce	Weak integration into the national health system for some organisations	Strong PPP in place	Change in Policy is very slow
		Independent funding system	Lack of transparency of how funding is used to support the programme	Leveraging resources for increased services	Program tied to implementing NGO
	c. Private sector	Good infrastructure	Weak linkages with Government	Support from Government	Competion for better services
		Generate own income	Temporal Human Resource	Availabilty of insurance schemes and choice	Change of Government & Political Leadership
			Unaffordable services		
2	HMIS	The HMIS is in place	Indicators not dissagregated, reviewing and updating indicators takes very long	Support from partners	Multiple data collection tools by Partners

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
3	Health workforce	Different Cadres trained in FP	High attrition	Supported by various training Institutions and partners	Limited funds to support more human resource
4	Medicines and technology	Decentarlized distribution points	Inefficient Supply Chain	Partner Support	Some FP commodities are partner dependant
5	Health financing	8 year FP costed plan, budgeted activities for capacity building by government and partners	inadequate fundig for FP, limited partners providing PPFP	Plans to scale up to other districts	Competing needs for other FP activities
6	Leadership and governance	Central FP TWG in place, a good platform to implement FP programs in districts	Weak FP TWG at provincial and district level, inadequate linkages between labour ward and FP units in most of the facilities	Availabilty of health care providers to be trained in PPFP and a very high unmet need.	Political, religious, cultural and traditional myths and misconceptions for PPFP
7	Community and Sociocultural				
	a. Community-based	Availability of CBDs, SMAGs, CHWs	Shortage of POP and indaquate information on PPFP	High unmet need for FP	High attrition rate due to lack of motivation
		Sentised opinion leaders in communities eg FP champions	Lack of infrastructure for the provision of PPFP	High demand for FP	Not fully integrated in the health care system
		Favourable interaction between the community, CHWs and HCP	Inadequate skills as well as long distances to reach health centres	FP links to socio-economic status of individual families	Disparity of information and skills
	b. Mobile outreach	Multiple contact able to address multiple health issues	Inadequate infrastructure to provide PPFP and Postnatal	Alternative non traditional service delivery structures eg tents, mobile hospitals	Unable to capture special groups such as adolescents and the disabled
		Leveraging resources to do many health activities	Inadequate logistics and trained staff	Engagement of communities to leverage resources	High cost of doing out reach
		Provision of access in under served communities	low acceptance of the service	Support community champions to conduct more FP sensitisations	Poor road network/ seasonal challenges
	c. Social marketing	Availability of FP socially marketed products such as Ocs	Limited access to distribution in some areas	Ability to coordinate partners at central level	Donor dependancy

Health System Dimension		Strenths	Weaknesses	Opportunities	Threats
7	c. Social marketing	Easy access to socially marketed products	No consumer contact/ no data on use and acceptability	Larger target audience	Inferior and unfamiliar products
		Multiple channels for social marketing including CBDs, drug stores, pharmacies.	No follow up in case of misuse or failures	High unmet need for FP	Unregulated products on the market

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

PPFP Country Programming Strategies Worksheet

Country:	Zambia	Country Coordinator:	Dr. Angel Mwiche

VI. PPFP Implementation Plan

Reflect on both the PPFP situational analysis on sheet III. and the SWOT analysis on sheet V. to evaluate whether your country's existing PPFP programs can be improved, or whether entirely new programs should be proposed. For example, given your country's context:

1. Should the existing programs better target certain hard-to-reach or underserved populations?
2. Are there better contact points for PPFP integration than the ones used in existing programs?
3. Which contraceptive methods are likely to be most acceptable and available in the settings where women deliver in your country?
4. What additional health strengthening activities are needed to institutionalize each strategy?
5. What additional resources and sources of funds can be requested in annual budgeting processes?
6. Are there new key stakeholders who could be engaged?
7. Are there other implementing organizations that might be interested in PPFP activities?

In this sheet, either revise your existing PPFP programs from sheet IV. or substitute alternative programs as your country's future PPFP programs. Carry over any activities that already are achieving a program goal but take a prospective view on their implementation when revising the remaining details. Add as many new activities are needed. To help determine "total cost over timeframe," visit: http://www.fhi360.org/resource/costed-implementation-plans-guidance-and-lessons-learned. This table will be the start of your country's PPFP Implementation Plan.

Future PPFP Program 1:	
National guidelines and policy	
Activity 1:	**National FP guidelines updates to include new WHO evidence on PPFP before they are finalized**
Timeframe	**by October**
Evidence of success	**Finalized and Printed copies of the guidelines**
Total cost over timeframe	**TBD**
Additional considerations	**advocavy, stakeholder engagement, TWG**
Key stakeholders	**MCDMCH, MOH, National FP TWG members**
Implementing agency(ies)	**MCDMCH,**
Activity 2:	
Timeframe	
Evidence of success	
Total cost over timeframe	
Additional considerations	

Key stakeholders	
Implementing agency(ies)	
Activity 3:	
Timeframe	
Evidence of success	
Total cost over timeframe	
Additional considerations	
Key stakeholders	
Implementing agency(ies)	
Indicator(s) (Data Source):	
Future PPFP Program 2:	
Activity 1:	**Inclusion of PPFP indicators in the HMIS**
Timeframe	**by end of 2016**
Evidence of success	**PPFP data been collected and available for use**
Total cost over timeframe	**TDB**
Additional considerations	**Timing of this will be dependnant on the schedulled national HIMS reviews,**
Key stakeholders	**MCDMCH, MOH, National FP TWG memebr organizations/ members**
Implementing agency(ies)	**MOH, MCDMCH**
Activity 2:	
Timeframe	
Evidence of success	
Total cost over timeframe	
Additional considerations	
Key stakeholders	

Implementing agency(ies)	
Activity 3:	
Timeframe	
Evidence of success	
Total cost over timeframe	
Additional considerations	
Key stakeholders	
Implementing agency(ies)	
Indicator(s) (Data Source):	
Future PPFP Program 3:	
Activity 1:	Normalize PPFP provison as a standard among labour and delivery providers
Timeframe	by
Evidence of success	PPFP offered in immediately post paturm
Total cost over timeframe	TBD
Additional considerations	Reorientation, training, availability of PPFP Job aids and commodities in delivery rooms,
Key stakeholders	MCDMCH, MOH, national FP TWG members
Implementing agency(ies)	
Activity 2:	Strengthern community particpation in PPFP
Timeframe	
Evidence of success	Increases demand and uptake of PPFP
Total cost over timeframe	TBD
Additional considerations	Working with champions, Commuinty leaders, CHWs
Key stakeholders	MCDMCH, MOH, national FP TWG members, Parliamentarians, Religious leaders, Traiditional leaders
Implementing agency(ies)	
Activity 3:	

Timeframe	
Evidence of success	
Total cost over timeframe	
Additional considerations	
Key stakeholders	
Implementing agency(ies)	
Indicator(s) (Data Source):	

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PPFP Country Programming Strategies Worksheet

Country:	Zambia	Country Coordinator:	ywe

VII. Considerations for Scale-up

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

	Scale-up Consideration	Yes	No	More Information/Action Needed
Future PPFP Program 1:		**Post Partum Family Planning- Public institutional level**		
1	Is input about the program being sought from a range of stakeholders?	yes		sharing work plans with stake holders to see who is doing what and in order for stake holders to buy-in government work planyes
2	Are individuals from the implementing agency(ies) involved in the program's design and implementation?	yes		Implementing partners currently involved in planning and are expected to be involved in implementation
3	Does the program have mechanisms for building ownership in the implementing agency(ies)?	yes		The postnatal clinics are mainly run in government clinics were postnatal family planning is being implemented by all organisations
4	Does the program address a persistent health or service delivery problem?	yes		all problems to demand, service delivery and infrastructure are constantly on the agenda
5	Is the program based on sound evidence and preferable to alternative approaches?	yes		every contact with the women should be taken as an opportunity
6	Given its financial and human resource requirements, is the program feasible in the local settings where it is to be implemented?	yes		feasible if identified gaps are worked on
7	Is the program consistent with existing national health policies, plans and priorities?	yes		Scailing up family planning , RH policy and Sixth National development plan and National Health strategic plan
8	Is the program being designed in light of agreed-upon stakeholder expectations for where and to what extent activities are to be scaled-up?	yes		all identified stakeholders buy-in government work plan
9	Does the program identify and take into consideration community, cultural and gender factors that might constrain or support its implementation?	yes		without the participation the community cannot succeed
10	Have the norms, values and operational culture of the implementing agency(ies) been taken into account in the program's design?	yes		we try as much as possible to adhere to values and practices of different partners.

	Scale-up Consideration	Yes	No	More Information/Action Needed
11	Have the opportunities and constraints of the political, policy, health-sector and other institutional factors been considered in designing the program?	yes		There is political will
12	Have the activities for implementing the program been kept as simple as possible without jeopardizing outcomes?	yes		outcomes are expected to be the same as the traditional family planning clinic
13	Is the program being implemented in the variety of sociocultural and geographic settings where it will be scaled up?	yes		can be scaled up anywhere
14	Is the program being implemented in the type of service-delivery points and institutional settings in which it will be scaled up?	yes		
15	Does the program require human and financial resources that can reasonably be expected to be available during scale-up?	yes		As explained earlier
16	Will the financing of the program be sustainable?		no	
17	Does the health system currently have the capacity to implement the program? If not, are there plans to test ways to increase health-systems capacity?	yes		if the identified gaps are addressed
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?	yes		
19	Is there provision for early and continuous engagement with donors and technical partners to build a broad base of financial support for scale-up?		no	because donor dependence is unpredictable
20	Are there plans to advocate for changes in policies, regulations and other health-systems components needed to institutionalize the program?	yes		in the area of task shifting
21	Does the program include mechanisms to review progress and incorporate new learning into its implementation process?	yes		all programs are reviewed to assess progress
22	Is there a plan to share findings and insights from the program during implementation?	yes		sharing is done through the technical working group
23	Is there a shared understanding among key stakeholders about the importance of having adequate evidence related to the feasibility and outcomes of the program prior to scaling up?		no	But the progress of discussion has started through the technical working group
	Scale-up Consideration	Yes	No	More Information/Action Needed

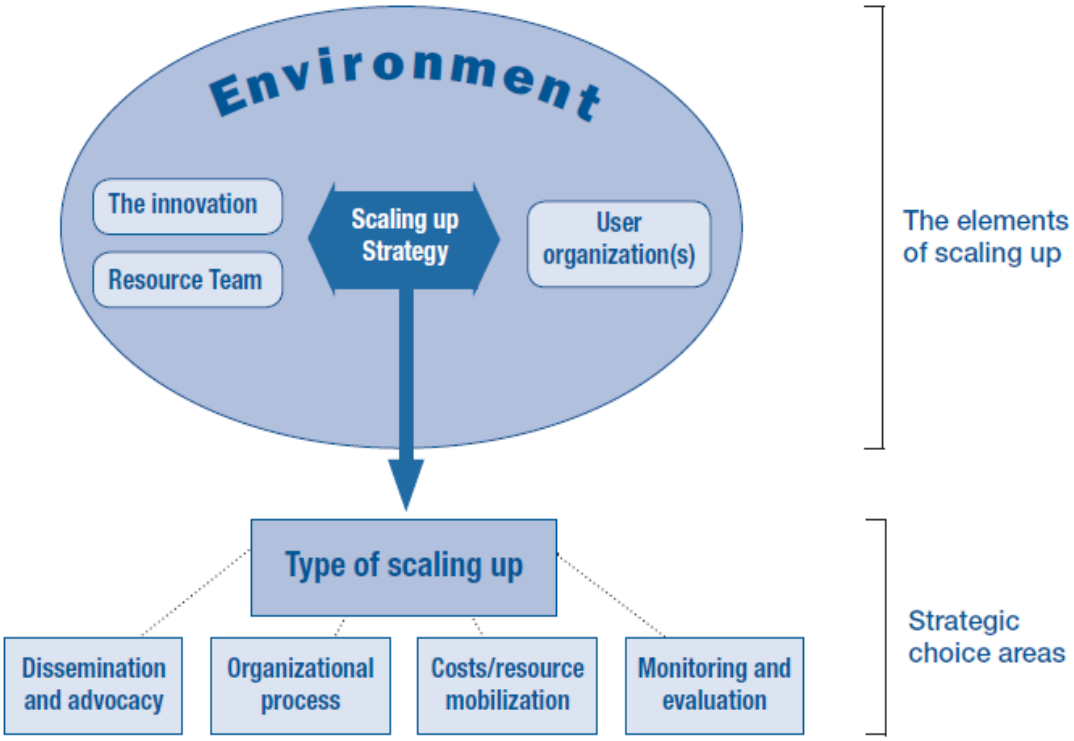
Scale-up Consideration		Yes	No	More Information/Action Needed
Future PPFP Program 2:	**Post Partum Family Planning- Communty level**			
1	Is input about the program being sought from a range of stakeholders?	yes		different stakeholders implementing at community level
2	Are individuals from the implementing agency(ies) involved in the program's design and implementation?	yes		
3	Does the program have mechanisms for building ownership in the implementing agency(ies)?	yes		It is government policy to provide postnatal services
4	Does the program address a persistent health or service delivery problem?	yes		Areas of training, commodity provision and M&E
5	Is the program based on sound evidence and preferable to alternative approaches?	yes		
6	Given its financial and human resource requirements, is the program feasible in the local settings where it is to be implemented?	yes		if identified gaps are resolved
7	Is the program consistent with existing national health policies, plans and priorities?	yes		
8	Is the program being designed in light of agreed-upon stakholder expectations for where and to what extent activities are to be scaled-up?	yes		
9	Does the program identify and take into consideration community, cultural and gender factors that might constrain or support its implementation?	yes		this is even more important at community level
10	Have the norms, values and operational cultrue of the implementing agency(ies) been taken into account in the program's design?	yes		
11	Have the opportunities and constraints of the political, policy, health-sector and other institutional factors been considered in designing the program?	yes		there political will
12	Have the activities for implementing the program been kept as simple as possible without jeopardizing outcomes?	yes		
13	Is the program being implemented in the variety of sociocultural and geographic settings where it will be scaled up?	yes		
14	Is the program being implemented in the type of service-delivery points and institutional settings in which it will be scaled up?	yes		
15	Does the program require human and financial resources that can reasonably be expected to be available during scale-up?	yes		Though at level it likely to be lighter than the facility level

	Scale-up Consideration	Yes	No	More Information/Action Needed
16	Will the financing of the program be sustainable?		no	
17	Does the health system currently have the capacity to implement the program? If not, are there plans to test ways to increase health-systems capacity?		no	it has difficult finance the insetives
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?	yes		
19	Is there provision for early and continuous engagement with donors and technical partners to build a broad base of financial support for scale-up?	yes		has been discussed at stakeholders meetings
20	Are there plans to advocate for changes in policies, regulations and other health-systems components needed to institutionalize the program?	yes		
21	Does the program include mechanisms to review progress and incorporate new learning into its implementation process?	yes		
22	Is there a plan to share findings and insights from the program during implementation?	yes		
23	Is there a shared understanding among key stakeholders about the importance of having adequate evidence related to the feasibility and outcomes of the program prior to scaling up?	yes		Partners buying-in government work plan
	Scale-up Consideration	**Yes**	**No**	**More information/action needed**
Future PPFP Program 3:				
1	Is input about the program being sought from a range of stakeholders?			
2	Are individuals from the implementing agency(ies) involved in the program's design and implementation?			
3	Does the program have mechanisms for building ownership in the implementing agency(ies)?			
4	Does the program address a persistent health or service delivery problem?			
5	Is the program based on sound evidence and preferable to alternative approaches?			

	Scale-up Consideration	Yes	No	More Information/Action Needed
6	Given its financial and human resource requirements, is the program feasible in the local settings where it is to be implemented?			
7	Is the program consistent with existing national health policies, plans and priorities?			
8	Is the program being designed in light of agreed-upon stakholder expectations for where and to what extent activities are to be scaled-up?			
9	Does the program identify and take into consideration community, cultural and gender factors that might constrain or support its implementation?			
10	Have the norms, values and operational cultrue of the implementing agency(ies) been taken into account in the program's design?			
11	Have the opportunities and constraints of the political, policy, health-sector and other institutional factors been considered in designing the program?			
12	Have the activities for implementing the program been kept as simple as possible without jeopardizing outcomes?			
13	Is the program being implemented in the variety of sociocultural and geographic settings where it will be scaled up?			
14	Is the program being implemented in the type of service-delivery points and institutional settings in which it will be scaled up?			
15	Does the program require human and financial resources that can reasonably be expected to be available during scale-up?			
16	Will the financing of the program be sustainable?			
17	Does the health system currently have the capacity to implement the program? If not, are there plans to test ways to increase health-systems capacity?			
18	Are appropriate steps being taken to assess and document health outcomes as well as the process of implementation?			
19	Is there provision for early and continuous engagement with donors and technical partners to build a broad base of financial support for scale-up?			

	Scale-up Consideration	Yes	No	More Information/Action Needed
20	Are there plans to advocate for changes in policies, regulations and other health-systems components needed to institutionalize the program?			
21	Does the program include mechanisms to review progress and incorporate new learning into its implementation process?			
22	Is there a plan to share findings and insights from the program during implementation?			
23	Is there a shared understanding among key stakeholders about the importance of having adequate evidence related to the feasibility and outcomes of the program prior to scaling up?			

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



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Country:	Zambia	Country Coordinator:	**Dr. Angel Mwiche**

VIII. PPFP Action Plan

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

	Task	Primary person responsible	Secondary person responsible	Deadline	What problems do you anticipate? What will you do when you encounter these (or other) problems?
1	Finalize action plan	Dyness	Jully	end of July	Time limited and therefore this activity should prioritised the next few days.
2	Dissemination of action plan to national TWG	Dyness	Angel Mwiche	end of August	If done through mail, the response is likely to be poor. It should therefore done in a presentation form and allow discussion and answer session
3	Dissemination of action plan to all stake holders	Dyness	Angel Mwiche	End of September	.Stake holder participation is likely to be more effective if a meeting is called rather than sharing electronically
4	Endorse of Plan by MCDMCH/MOH PS	Caroline Phiri	Angel Mwiche	End of October	MoH might delay the endorsement if not engaged at an earlier stage than this
5	Immplementation of Action plans	Angel Mwiche	Mary Nambao	First Quarter 2016	Monitoring and Evaluation component should part and parcel of the Action Plan
6					
7					
8					
9					

	Task	Primary person responsible	Secondary person responsible	Deadline	What problems do you anticipate? What will you do when you encounter these (or other) problems?
10					
11					
12					
13					
14					
15					
16					
17					
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20					