Republic of Zambia

Family Planning Services

Integrated Family Planning Scale-up Plan 2013 - 2020

Integrated Family Planning Scale-up Plan 2013 - 2020

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome; *see HIV*
ANC	Antenatal Care
ART	Anti-retroviral Therapy
ASRH or AYSRH	Adolescent and Youth Sexual and Reproductive Health
BCC	Behaviour Change Communication
BMGF	Bill & Melinda Gates Foundation
BTL	Bilateral Tubal Ligation
CBD	Community Based Distribution
CHA	Community Health Assistant
CHAZ	Churches Health Association of Zambia
CHW	Community Health Worker
CO	Clinical Officer
CPR	Contraceptive Prevalence Rate; *includes modern, traditional and folk methods; see MCPR*
CSO	Central Statistical Office
CYP	Couple Years of Protection
DfID	Department for International Development
DFPP	Dedicated family planning providers
DHO	District Health Office
DHS	Demographic and Health Survey; *also called ZDHS for Zambia DHS*
EMLIP	Essential Medicines Logistics Improvement Programme
eMTCT	Elimination of Mother-to-Child Transmission (of HIV/AIDS); *see PMTCT*
FP	Family Planning
GNC	General Nursing Council
GRZ	Government of the Republic of Zambia
HCW	Healthcare Worker
HCP	Healthcare Provider
HIV	Human Immunodeficiency Virus; *see AIDS*
HMIS	Health Management Information System
HPCZ	Health Professionals Council of Zambia
HRH	Human Resources for Health
HTC	HIV Testing and Counseling
IEC	Information, Education, Communication
IUD or IUCD	Intrauterine Contraceptive Device
LARC	Long-acting Reversible Contraceptive; *includes implants and IUDs*
LAM	Lactational Amenorrhea Method
LMU	Logistics Management Unit
MCDMCH	Ministry of Community Development, Mother and Child Health
MCPR	Modern Contraceptive Prevalence Rate (women married and in-union); *see CPR*
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MOESVTEE	Ministry of Education, Science, Vocational Training and Early Education

MOH	Ministry of Health
MSL	Medical Stores Limited
PAC	Post-Abortion Care
PHO	Provincial Health Office
PMTCT	Prevention of Mother-to-Child Transmission (of HIV/AIDS); *see eMTCT*
PPIUD or PPIUCD	Postpartum Intrauterine Contraceptive Device
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
SDP	Service Delivery Point
SGBV	Sexual and Gender-Based Violence
SMAG	Safe Motherhood Action Group
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
TOT	Training of Trainers
TST	Technical Support Team
TWG	Technical Working Group
U5MR	Under 5 Mortality Rate
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
WRA	Women of Reproductive Age; *women 15-49 years of age*
ZMW	Zambian Kwacha (rebased from ZMK)

Activity categories

D	Demand
SDA	Service delivery and access
PSC	Procurement and supply chain
PE	Policy and environment
F	Financing
SMC	Supervision, monitoring and coordination

Preface

Foreword from the Honourable Minister of Community Development, Mother and Child Health

Hon. Dr. Joseph Katema

Zambia has one of the highest total fertility rates (6.2 children per woman) in the world, and unfortunately also one of the highest maternal mortality ratios (591 per 100,000 live births). Our efforts in scaling up of modern family planning methods are motivated by proof that this is one of the most effective ways to prevent maternal, infant, and child mortality. Moreover, increasing access to family planning has supplementary social and economic benefits, such as increasing educational attainment, reducing poverty and promoting gender equality.

This Eight-Year Scale-up plan is intended to increase the contraceptive prevalence rate for modern methods from 33% to 58% by 2020, in line with the commitments that were made at the London Summit in July 2012 by the Government of the Republic of Zambia. The plan was prepared by the Ministry of Community Development, Mother and Child Health (MCDMCH) in collaboration with its partners.

The Eight-Year Scale-up plan focuses on a number of key strategic priorities that will help us reach our objective, including: strengthening demand for family planning services by providing easily-accessible and targeted information; building the capabilities of providers and increasing the health system capacity to deliver high quality contraceptive services to provide greater choice of methods; providing in and out of school adolescents with accurate and up-to-date sexual and reproductive health information; and, increasing coverage and access to quality integrated family planning services to people living in rural and underserved areas.

The MCDMCH would like to encourage all stakeholders to commit to this important scale-up plan to reach our family planning goal for 2020, so that we can continue to save lives, and women and families can continue to fully enjoy the benefits of family planning.

Hon Dr. Joseph Katema (MP);
MINISTER - COMMUNITY DEVELOPMENT, MOTHER AND CHILD HEALTH

MESSAGE BY HER EXCELLENCY DR. CHRISTINE KASEBA-SATA

THE FIRST LADY OF THE REPUBLIC OF ZAMBIA

Working as an advocate in promoting mother and child health and more importantly family health for a better Zambia, I have witnessed first-hand the way in which sexual reproductive health information and services, including family planning, can increase opportunities for families, uplift them out of poverty, and enable young people to realise their full potential.

The fact that family planning is not about stopping people from having children nor is it only a woman's issue cannot be over emphasized. It is about enabling men and women, to make informed decisions about the welfare of the woman, existing children and the family as a whole. Family planning helps individuals and communities maintain their overall health by supporting men and women to have children when their health, financial and personal circumstances are optimal. There is no doubt that increasing access to family planning creates proven benefits in women's health, child survival and HIV prevention. This is a vision I strongly believe in, and have dedicated a great proportion of my life trying to support it.

Family planning saves lives and saves Nations!

Zambia is experiencing the largest youth population ever in its history, with over 80% of the population being below the age of 35 years and the majority being rural based. Among these are many adolescents who are vulnerable to unintended pregnancies and sexually transmitted infections due to lack of knowledge about sex, reproductive health and relationships and low literacy levels. We must empower our young people with the knowledge and skills, to make informed choices about their sexual health.

I am therefore delighted to be part of this momentous milestone of producing Zambia's first ever National Family Planning Scale-up plan to be implemented from 2013 to 2020. Universal access to family planning is a human right, central to gender equality and women's empowerment, and a key factor in reducing poverty and achieving the Millennium Development Goals.

Some of the key innovations reflected in the plan include Social franchising, greater involvement of men and gate keepers, taking family planning to the rural and underserved population as well as promoting long acting reversible contraceptives through outreach, camping and mobile approaches.Though I recognise that the goals laid out in the family planning scale-up plan are ambitious, I strongly believe that these will be achieved with collective action from the Government and all stakeholders.

Hon. First Lady of Zambia, Dr. Christine Kaseba

Context for the plan's development

As a result of the London Summit on Family Planning, which was held on July 11th, 2012, and renewed global interest and support, Zambia and many other countries have developed action plans for family planning. Following the commitments made at the Summit, the Government of the Republic of Zambia began to develop its Eight-Year Family Planning Scale-Up plan in September 2012, to ensure that the commitments are put into place and the objectives be met by 2020.

The plan was further developed under the guidance and oversight of MCDMCH and with support from DfID and by consultants from FHI360 and MSI. A draft version of the plan was presented by the honourable Minister of Community Development, Mother and Child Health, and Her Excellency, the First Lady, during the national repositioning of FP launch at Kalingalinga clinic in February 2013.

The consultants from FHI360 and MSI further advanced and finalized the plan. Based on a request from MCDMCH to cooperating partners for additional help in costing tplan, consultants from Futures Group/Health Policy Project supported by USAID and other consultants supported by the Bill & Melinda Gates Foundation (BMGF), worked under the direction of MCDMCH's family planning team throughout June and July 2013 to refine the costs and define an implementation and monitoring roadmap. The final plan was presented to MCDMCH and partners for their approval in August 2013.

Throughout this process, stakeholders have given significant input to ensure the plan represents the best interests of MCDMCH and the Zambian people that it serves, while taking into account suggestions from partners, donors, and other government departments. The original elements of the plan were developed by the Family Planning Technical Working Group (FP TWG), and were further refined in working sessions with this group. Interviews with more than 15 key partners, donors, and other government departments highlighted each organization's concerns and current role. Key questions were presented to the FP TWG for their decision-making in situations where the MCDMCH requested their guidance and expertise. Finally, the MCDMCH asked partners for any final comments or input into the plan before it was finalized.

Acknowledgments

The plan's development was led by the Director and Deputy Director of Maternal Child Health at MCDMCH. They were greatly supported in the process by their technical team at the Department of Mother Child Health in the development of the plan itself, both initially and through ongoing dialogue with partners.

Consultant support for the development of the plan was provided by Futures Group/Health Policy Project, CHAI and others and was funded by a tripartite of partners, including DfID, BMGF and USAID.

Other support from the GRZ came from MOH and MSL, who provided a valuable understanding of how the healthcare system and commodity distribution work.

In addition to the above, a variety of donors and partners have provided valuable input through the Family Planning Technical Working Group and interviews, including:

- Bill & Melinda Gates Foundation (BMGF)
- ChildFund
- Churches Health Association of Zambia (CHAZ)
- Communications Support for Health (CSH)
- Family Health International (FHI360)
- JHPIEGO
- John Snow, Inc. (JSI)
- Marie Stopes International (MSI)
- Medical Stores Limited (MSL)
- PATH
- Planned Parenthood Association of Zambia (PPAZ)
- Scaling Up Family Planning in Zambia (SUFP)
- Society for Family Planning (SFH)
- United Nations Population Fund (UNFPA)
- United States Agency for International Development (USAID)
- Youth Vision Zambia
- Zambia Integrated Services Strengthening Program (ZISSP)
- And all other members of the Family Planning Technical Working Group.

Prof: Elwyn Chomba

PERMANENT SECRETARY
MINISTRY OF COMMUNITY DEVELOPMENT MOTHER AND CHILD HEALTH

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Executive Summary

Family planning is a key component to preventing maternal, infant, and child mortality. Family planning can reduce maternal mortality by reducing the number of unintended pregnancies, the number of abortions, and the proportion of high-risk births; as well as contributing to improved health for women, their families, and communities. Family planning also offers women and their families the ability to plan the timing and number of children they desire.

The Government of the Republic of Zambia has committed to increasing the contraceptive prevalence rate for modern methods (women married or in union) from 33% in 2007 to 58% by 2020. The development and implementation of the Eight-Year Integrated Family Planning Scale-Up Plan 2013-2020, with the support of partners, will enable us to reach this objective

Strategic priorities were identified to ensure the current gaps in family planning in Zambia are adequately addressed. These are:

- FP demand generation and behaviour change communication: "To strengthen demand for family planning services by repositioning FP as a key driver in development, and providing targeted, easily-accessible and accurate information to the population"
- Adolescents and youth: "To more effectively target and serve adolescents and youth with quality accessible sexual and reproductive health information and services in and out of school"
- Staff and training: "To build capabilities of providers and increase capacity to deliver high quality contraceptive services, including long-acting reversible contraceptives"
- Rural and underserved access to FP services: "To increase coverage and access to quality integrated FP services available to those living in rural and underserved areas"
- Stockouts at service delivery points: "To improve the distribution, availability and security of family planning commodities from the central level to service delivery points, including both contraceptives and consumables"
- FP governance structure and program coordination: "To strengthen the central, provincial and district-level FP structures to better coordinate and monitor government and partner activities, in order to deliver services efficiently"

Reaching Zambia's ambitious goal of 58% of women who are married or in union using a modern contraceptive (MCPR) is ambitious, and must be match with commensurate support in the areas of human resources, financing, and political commitment from national to community levels throughout the country.

The cost of the total plan is 591 million ZMW, or $109 million USD, which will increase the number of women in Zambia currently using modern contraception from approximately 1 million to over 1.8 million between 2013 and 2020. For the period from 2013 to 2020, the annual cost of the plan is about 74 million ZMW. The activities and accompanying costs in this plan are specific and additional to primary health care services and systems in Zambia that are required to strengthen family planning as an integral part to improving the health and well-being of women, men, youth, and their communities. The activities, indicators, and

accompanying costs in this plan will assist the Government and partners to mobilize resources, and to monitor the implementation of Zambia's family planning program.

Section 1: Introduction

The Global Context

Family planning is one of the most cost-effective ways to prevent maternal, infant, and child mortality. Family planning can reduce maternal mortality by reducing the number of pregnancies, the number of abortions, and the proportion of births at high risk.[1] It has been estimated that meeting women's need for modern contraceptives would prevent about one quarter to one-third of all maternal deaths, saving 140,000 to 150,000 lives a year.[2] Family planning offers a host of additional health, social, and economic benefits: it can help reduce infant mortality, slow the spread of HIV/AIDS, promote gender equality, reduce poverty, accelerate socioeconomic development, and protect the environment.

Yet today more than 200 million women and girls in developing countries who wish to delay, prevent, limit, or space pregnancies are not using a modern contraceptive method. Among women of reproductive age in developing countries, 57% (867 million) are in need of contraception because they are sexually active but do not want a child in the next two years. Of these 645 million (74%) are using modern methods of contraception; the remaining 222 million are not, resulting in significant unmet need for modern methods.[3] In 2006, unmet need for family planning was added to the fifth Millennium Development Goal (MDG) as an indicator for tracking progress on improving maternal health[4].

On July 11 2012, family planning stakeholders from around the world united for the London Summit on Family Planning. The UK government through the Department for International Development (DFID) and the Bill and Melinda Gates Foundation partnered with UNFPA to host a gathering of leaders from national governments, donors, civil society, the private sector, the research and development community, and other interest groups to renew and revitalize global commitment to ensuring the world's women and girls, particularly those living in low-resource settings, have access to contraceptive information, services, and supplies.

The objective of the summit was to "mobilize global policy, financing, commodity and service delivery commitments to support the rights of an additional 120 million women and girls in the world's 69 poorest countries to use contraceptive information, services and supplies,

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1 Lule E, Hasan R, Yamashita-Allen K. Global trends in fertility, contraceptive use and unintended pregnancies. In: Lule E, Singh S, Chowdhury SA, eds. Fertility Regulation Behaviors and Their Costs: Contraception and Unintended Pregnancies in Africa and Eastern Europe & Central Asia. Health, Nutrition & Population Discussion Paper. Washington, DC: World Bank; 2007:8–39. Available at: http:// go.worldbank.org/BZSBNC53A0

2 Singh S, Darroch JE, Vlassof M, Nadeau J. Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care. New York: Alan Guttmacher Institute; 2003. Available at: www.guttmacher.org/pubs/addingitup.pdf.

3 Guttmacher Institute and United Nations Population Fund (UNFPA), 2012. Fact sheet.

4 Bernstein S, Edouard L. Targeting access to reproductive health: giving contraception more prominence and using indicators to monitor progress. Reproductive Health Matters. 2007; 15(29):186–191.

without coercion or discrimination, by 2020." Doing so would prevent a staggering 100 million unintended pregnancies, 50 million abortions, 200,000 pregnancy- and childbirth-related maternal deaths, and 3 million infant deaths.[5]

The London Summit on Family Planning committed to:

1) Increase demand and support for family planning by removing barriers to access and use
2) Improve supply chains, and systems and service delivery models and procure more affordable and quality contraceptives through better global coordination and include new methods for expanded choice
3) Improve market dynamics, including country forecasting capabilities and increased availability and quality of a range of family planning methods
4) Promote accountability at global and country levels through improved monitoring and evaluation
5) Advocate for sustained government and donor funding

On a country level, the key steps to ensure increased uptake of family planning include:

- Promote best practices,
- Support new innovations,
- Improve supply chains,
- Increase contraceptive supply,
- Strengthen accountability, and
- Support advocacy.

Zambia was represented at the London Summit by a team of experts that included the Minister, MCDMCH and the First Lady of Zambia. The Minister, MCDMCH made the following commitments on behalf of the GRZ:

1) Double budgetary allocation to family planning commodities, striving to eliminate the unmet need for family planning, and improve universal coverage through an expanded method mix and increased access, particularly to the underserved population.
2) Address policy barriers to allow task shifting to community health assistants (CHAs) and trained community based distributors (CBDs) to increase access to the underserved communities.
3) Initiate new dialogue, led by the MCDMCH, with religious and traditional leaders at local level to generate demand, dispel the myths and 'open up the dialogue' on family planning.

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5 Family Planning Summit 2012, Technical Note: date sources and methodology for calculating 2012 baseline, 2020 objectives, impacts and costings, Family Planning Summit Metrics Group, 2012

This Plan evolves from these commitments and provides a roadmap for achieving the GRZ's goals for improving access to family planning and reducing maternal mortality through a concerted national effort to scale up family planning over eight years.

The Zambian Context

Zambia is a large country divided administratively into ten provinces and 106 districts. It has a total population of 13,092,666 and an almost equal gender distribution. Although the country is highly urbanized with 39% of the population living in cities[6], population density is low in rural areas, associated with an average nation-wide density of 17.3 persons per square kilometre. Life expectancy at birth is similar to that of other populations in the regionat 52.6 years.[7]

The Zambian fertility rate of 6.2 births per woman (4.3 in urban areas and 7.5 in rural areas) is one of the highest in the world. This is associated with an annual population growth rate of 2.8%, resulting in a projected population of 15.5 million by 2015, doubling to 30 million by 2030. The population is predominately young with 17.2% under the age of five, and 50% under 15 years of age.[8]

In Zambia, the uptake of family planning (FP) methods is relatively low compared to other Eastern African countries. The contraceptive prevalence rate (CPR) is at 41% for all methods (32.7% for modern FP methods) and the unmet need for FP is 27%. However, the Ministry of Health (MOH) and the Ministry of Community Development, Mother and Child Health (MCDMCH) have recently initiated a variety of efforts to increase FP uptake and, with support from partners, have achieved some notable successes: increasing access to long-acting FP methods; enlarging programs of community-based distribution of condoms and pills; piloting community-based provision of injectables; and substantial work on the standardization of training materials.[9]

For the development of this plan, the family planning situation in Zambia was analysed along six components: demand; service delivery and access; procurement and supply chain; policy and environment; financing; and supervision, monitoring and coordination. The following sections detail the findings of the landscape analysis for each of the six components.

Demand

Awareness of FP among Zambians is high. According to the 2007 ZDHS, 97% of all women and 99% of all men had heard of FP. However, knowledge does not always translate into use of FP services. Demand-side obstacles that prevent adoption of FP among those who know about it include actual or feared partner/spousal disapproval, myths, rumours and misinformation about FP and specific methods, and fears of side effects and health concerns. In particular, women in remote rural areas, youth, men, or groups with special

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6 Central Statistical Office (CSO) projections, 2010.

7 Central Statistical Office (CSO) projections, 2010.

8 Central Statistical Office (CSO), Ministry of Health (MOH), Tropical Diseases Research Centre (TDRC), University of Zambia, and Macro International Inc. 2009. Zambia Demographic and Health Survey 2007. Calverton, Maryland, USA: CSO and Macro International Inc.

9 Chin-Quee D, Katz K, Mbewe RK, Jumbe L, and Bratt J. *Expanding Community Based Access to Injectable Contraception: Results of a Pilot Study in Zambia*. Research Triangle Park, NC, USA and Lusaka, Zambia: FHI 360 and Zambia Ministry of Health, 2011.

needs, such as HIV-infected persons, can be difficult to reach with accurate information to generate demand for family planning.

Lack of knowledge and accurate information is a particular barrier for long-acting, reversible contraceptives (LARC) such as implants and intrauterine devices (IUDs). In 2007, of Zambian women, 92.2% were familiar with condoms, 91.5% with pills, 86.8% with injectables, but only 43.3% with implants and 35.8% with IUDs.[10] In addition, representatives of the MCDMCH and of NGOs in Zambia report that various negative myths and false beliefs about LARC exist in communities in Zambia, for example that implants and IUDs can travel around the body, becoming lodged in the brain, the heart or a growing foetus; and that fertility will not return after LARC removal. Some Zambian health care providers also have negative beliefs about IUDs in particular: that they cannot be used in nulliparous women and that they frequently cause infection.

Young women in Zambia are a key population requiring targeted demand generation efforts. Early childbearing, high fertility rates, inadequate access to maternal health services, coupled with HIV, complications during pregnancy and childbirth are the leading cause of death for young women aged 15-19 years in Sub-Saharan Africa[11]. Zambia has one of the highest adolescent birth rates in sub-Saharan Africa, as 27.9 % of teenage girls between 15 and 19 years of age have begun childbearing[12]. Coupled with this, Zambia also has a very high child marriage rate. Two out of five girls will be married before their 18th birthday and 73.6% are married by the time they are 20 years old.[13] In addition, 33.3% of women 20 – 24 use contraception of any kind[14] while unmet need for FP is reported by 21.3% of married women under age 20.[15] This unmet need is demonstrated by the fact that of the approximately 90,000 women who received post-abortion care in Zambia in 2010, 90% were under 20 years old.[16]

Table 1: Zambia – selected demographic, socio-economic and maternal health Indicators,

Indicator	Source	Status
Population	Central Statistics Office (CSO) 2010 Census,	13,092,666 million
Sex Ratio (Males per Female)	Calculated from CSO 2010 Census	0.96
Average Annual Population Growth Rate	CSO 2010 Census, based on 10 year period from 2000-2010	2.8%
Life Expectancy at Birth	CSO Projections	51.3 Years
Population Under the Age of 15 Years (%)	CSO, 2010 Census	45.4%

10 ZDHS2007, p.68.

11 UNFPA Eastern and Southern Africa (2012), Regional Programme Action plan (2012 – 2017)

12 ZDHS 2007

13 ZDHS2007, p. 94.

14 DHS2007, p. 73.

15 DHS2007, p. 108

16 TST interview with Adrienne Quintana, Country Director Marie Stopes International Zambia (MSIZ), June 2013.

Indicator	Source	Status
Urban Population	CSO, 2010 Census	39%
Poverty Levels	ZDHS 2007	67% (overall)
Maternal Mortality Ratio	CSO, 2010 Census	483 per 100,000 live births
Births attended by skilled health personnel	ZDHS 2007	47% of births
Contraceptive prevalence rate (modern methods among married women)	ZDHS 2007	32.7%
Contraceptive prevalence rate (modern methods all women of reproductive age)	ZDHS 2007	24.6%
Unmet need for Family planning	ZDHS 2007	26.6%
Teenage pregnancy rate	ZDHS 2007	27.9%

Source: Adapted from Ministry of Health, (2011). National Health Strategic Plan 2011 – 2015

Service Delivery and Access

Access

In order for FP to be accessible to women, it must be provided at an affordable cost, at a location reasonably close to home, according to a convenient schedule and in a setting where women feel free and comfortable.

Cost: In Zambia, direct cost is not a barrier to access of FP. All FP is free at Government of the Republic of Zambia (GRZ) facilities and is provided at low or no cost at NGO fixed sites, and for free at NGO outreach sites.

Location: Distance to a health facility is generally not an access barrier for the 39% of Zambian women who live in urban areas, where average travel time to a health facility is less than 20 minutes. However, it is often an access barrier for rural women, whose average travel time to a health facility is two hours and often longer in the rainy season.[17] However, 91.2% of rural women receive antenatal care[18] and 91.3%[19] of rural children receive at least one vaccination dose by the time they reach 12 months of age, suggesting that women can surmount the inconvenience of relatively lengthy travel to access health services that they value.[20]

Schedule: Routine FP services at GRZ and mission health care facilities are usually provided for very limited hours (e.g., a few hours on a single day each week). Also, the schedule for routine FP services is generally not coordinated with the provision of other popular services that women attend (e.g., under 5/immunization clinics). Therefore the

17 Hjortsberg CA, Mwikisa CN: "Cost of access to health services in Zambia," Health Policy and Planning; 17(1):71-77, 2002..

18 DHS2007, p.124.

19 DHS2007, p.142.

20 Zambia Demographic and Health Survey, 2007.

scheduling of services can be a barrier to access for women, as they may not be able to present at the clinic during the limited hours and may have difficulty travelling repeatedly to the clinic for different services provided on different days.

Setting: MCDMCH and NGO staff report that there generally is no negative social stigma associated with FP services in Zambia, except for women who are unmarried. As women do use GRZ and mission health care facilities to obtain valued services (such as antenatal care and child immunization), one can assume they are comfortable there; and married women also appear comfortable obtaining FP services. However, unmarried – especially young – women are constrained by the social stigma.

The physical infrastructure of fixed and mobile health care facilities in Zambia is generally adequate for providing FP. Most health centres (HCs) have a private clean area where a couple can receive counselling, and a woman can lie down – a requirement for LARC insertion.

Service Delivery

In the GRZ structure, FP activities fall under the jurisdiction of the MCDMCH and the MOH. Within GRZ, health care is provided within government and mission-owned facilities, including approximately 250 Health Posts (HPs), 1,000 Rural Health Centres (RHCs), 200 Urban Health Centres (UHCs), 71 Level 1/District Hospitals, 16 Level 2 Hospitals and six Level 3 Hospitals. FP services are available at almost all facilities, with the exception of those run by religious orders which do not support FP, and HPs, which have very limited clinical services.

Routine FP services in GRZ and mission health facilities generally include provision of the standard short-acting FP methods: condoms, pills and injectables. In some rural areas, condoms and pills are also available from community based distributors, and in urban areas, these are available from pharmacies and from the few private clinics that exist.

LARC services are much more limited. Though LARC is provided as a routine FP service in most large hospitals in Zambia, it is seldom provided as a routine service in GRZ FP clinics in HCs and other hospitals. Supply data from a subset of districts indicates that 34% of facilities requested implants and 4% of requested IUDs from the central store during January 2013, indicating that a minority of facilities are providing these services.[21]

The major reason for limited LARC provision is shortage of clinical staff, which is severe in the Zambian health sector and most severe in rural areas. Staff shortage is associated with conflicting or competing priorities and excessive workload for existing staff, resulting in inability to perform non-urgent and relatively time-consuming tasks such as providing LARC, even when a health care worker (HCW) who has been trained in LARC is present.

As shown in Table 2, the human resources for health (HRH) shortage mainly affects the cadres critical to providing family planning services such as nurses, midwives, clinical officers and doctors. Out of a total GRZ approved workforce for the MOH of 51,414; 66% of the positions were funded through the national budget in 2009, and 54% of the total funded positions were active as at October 2009.

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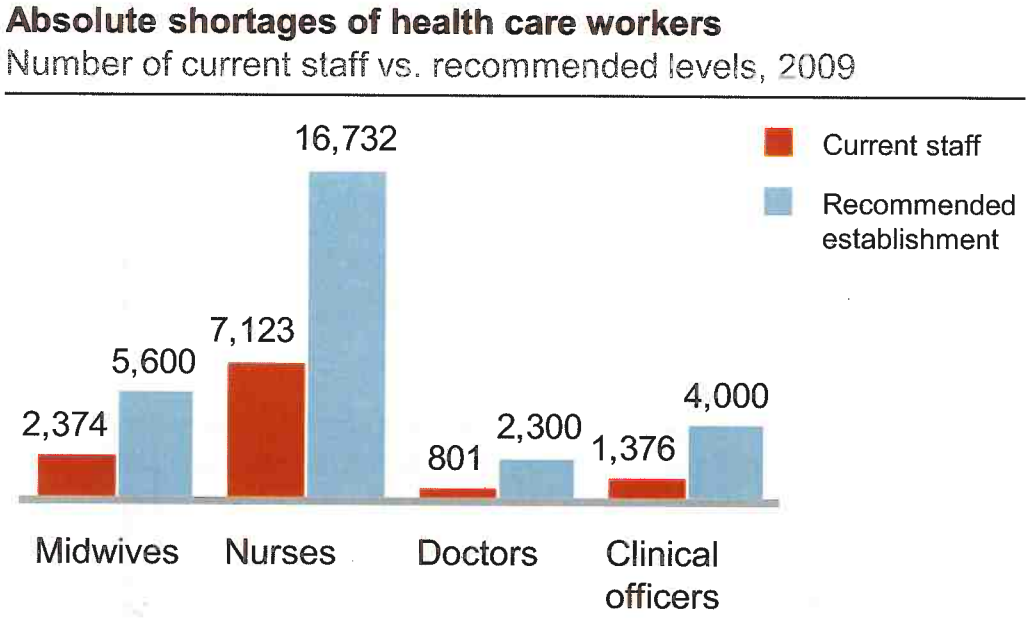
21 Personal communication from John Snow, Inc. staff, June 18, 2013.

Table 2: Staffing situation from 2005 to 2009[22]

Staff Category	2005	2009	RE	2005-2009 var	2005-2009 % abs change	2009-rec var	2009-rec % gap
Clinical Officers	1161	1376	4,000	215	19%	-2,624	66%
Doctors	646	801	2,300	155	24%	-1,499	65%
Midwives	2,273	2,374	5,600	101	4%	-3,226	58%
Nurses	6,096	7,123	16,732	1,027	17%	-9,609	57%

Chart 1: Number of active staff levels vs. establishment positions in MOH, 2009[23]



At many sites, there is no GRZ HCW who has been trained in LARC skills. In order to increase the provision of LARC as a component of routine FP services, several hundred GRZ HCWs have received in-service LARC training during the past few years by both GRZ and NGO trainers. MCDMCH and NGO representatives report that some HCWs who have completed in-service training are competent to provide LARC at their workplace but that others are not, largely because they have not had sufficient practical experience to be confident in their skills As a further complication, the standard GRZ LARC training program is expensive, because it involves approximately two weeks of off-site formal training for each group of trainees; in 2014, decentralization of training to the provinces may reduce training expense somewhat. In addition, it is planned that LARC will be more fully integrated into the pre-service curriculum for midwives (and possibly nurses) during the next few years.

22 Ministry of Health. (2011). National Health Strategic Plan 2011-2015, p.22. (RE = recommended establishment)

23 Ministry of Health. (2011). National Health Strategic Plan 2011-2015, p.22.

LARC services require specific equipment (surgical instruments and sterilisation facilities), commodities (the implant or IUD) and consumables (for skin cleaning, anaesthesia and bandaging). Not all health care facilities have the equipment required on site.

Because limited LARC services are provided by GRZ staff, the vast majority of IUDs and implants are instead provided by NGO partners. Almost every district in Zambia has at least one site where NGOs provide LARC via outreaches utilizing dedicated family planning providers (DFPPs). The DFPPs work at approximately 20 fixed NGO-managed sites and 600 GRZ and mission-run outreach sites, where NGO staff holds DFPP clinics on a regular basis – weekly, monthly or quarterly. NGOs using this model currently provide approximately 80% of the LARC in Zambia, primarily through the DFPPs, and have succeeded in rapidly expanding access to LARC for some Zambian women. Factors which have contributed to the success of these programs include: minimizing clinical staff needs by using a relatively small number of DFPPs to cover many locations; avoiding problems of conflicting clinical priorities by using dedicated FP staff; increasing convenience for women by scheduling DFPP clinics on the same days as under 5/immunization clinics; conducting the DFPP clinics at urban, peri-urban and rural locations that are close to where women live; and avoiding service interruptions caused by local stock-outs by supplying the equipment, commodities and consumables required.

Given the existing HRH challenges the family planning sector in Zambia must quickly and immediately adopt the most efficient, government-led service delivery model possible, while focusing on building the capacity of the health system to delivery FP in the long term.

Procurement and Supply Chain

Led by the MOH, the Reproductive Health Commodity Security Committee manages the forecasting and procurement process. Beginning in 2014, Medical Stores Limited (MSL), the parastatal company historically responsible for distribution of commodities, will assume responsibility for forecasting and procurement, so that one body is responsible for the entire commodity management process. Contraceptives are primarily procured by donors, although GRZ does have a dedicated budget line for RH commodities which include family planning commodities.

Family planning commodities are considered essential medicines in Zambia and are supplied to facilities as part of the essential medicine kit. Kits containing pre-fixed quantities of commodities based on catchment population are pushed to districts to be supplied to health centres. Higher level facilities order and receive supplies based on consumption directly from MSL.

At the central level, stock outs of FP commodities are infrequent, and are sometimes affected by global stock outs or missed commodity orders. However, stock outs are common at the health centre level, especially in rural areas. Causes cited for stock-outs include inadequate transport to transfer supplies from the district storage area to the health centre and, to a lesser extent, incorrect forecasting for and ordering of supplies. Low stocks of consumables are a constraint as they are provided in bulk to facilities and can be wiped out when large campaigns come through. MSL and GRZ is working to resolve these supply problems, through decentralization of warehousing and distribution and through direct ordering by HCs (combined with training of HC staff in supply management), changes that are projected to be completed in 2015.

Policy and Environment

Through the MOH and MCDMCH, the government has established an increasingly supportive environment for promoting FP and development in the country. The Government has also continued to develop policy, legal, regulatory, institutional and implementation frameworks that take into account the health needs of men, women and adolescents.

The GRZ recognizes that family planning contributes to the nation's development goals. Zambia' ambitious national development goal is to become "A Prosperous Middle Income Nation by 2030."[24] Specifically, Zambia's Vision 2030's population sector vision is to "maintain population trends which are commensurate with sustainable socio-economic development by 2030" through promoting "reproductive health services in order to achieve small and manageable family sizes especially in the rural areas". This vision is operationalized in the Sixth National Development Plan 2011-2015, which recognizes that a healthy population is critical to improved production and productivity and thus, investments in the health sector are essential to ensure sustainability of the nation's human capital base required for sustainable economic growth. The National Population Policy (2010) further outlines the link between development and population growth, and recognize the contribution of family planning in helping to match population growth to sustainable economic growth.

Therefore, the GRZ considers family planning to be a cross-cutting issue which requires a multi-sector response. The government is encouraging coordination of the private sector, cooperating partners and civil society in the implementation of family planning services. Additional policies in Zambia addressing reproductive health and family planning include: National Health Policy 2012; National Health Strategic Plan 2011-2015; National Reproductive Health Policy 2008; HIV Policy 2005; National AIDS Strategic Framework 2011-2015 (2011); Human Rights Act, and Termination of Pregnancy Act 1972.

While the number and scope of policies and guidelines including family planning and Sexual and Reproductive Health (SRH) has been increasing in recent years, the implementation of these policies has progressed at a slower pace due to a lack of human and financial resources for implementation. Therefore a focus on implementation and on addressing the necessary resource gaps is critical in order to achieve the goals of this Plan. In addition, a few specific policy gaps exist that if filled could greatly improve access to family planning in Zambia. These gaps include policies that enhance access to family planning methods at the community level via community health assistants (CHAs) and community-based distributors (CBDs) and eliminate age-related and socio-cultural barriers to access.

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24 Republic of Zambia. 2006. Zambia Vision 2030.

Financing

The GRZ provides a budget line for reproductive health to the MOH and MCDMCH, which is further split at the Ministry level into sub-categories including family planning, fistula care, adolescent health, and RH commodities (including contraceptives). The budget line for RH is currently included in both the budgets for the MOH and MCDMCH as the responsibility transitions between the two Ministries. However, the RH commodity budget line is only included under the MOH as this Ministry is still responsible for commodity procurement.

At the London Summit on Family Planning, the Minister of Community Development, Mother and Child Health committed on behalf of the GRZ to double the budget allocation to family planning.[25] Although this is a step in the right direction, the majority of contraceptives are still purchased through donor support, with the GRZ covering 8% of needs in the past 4 years, on average.[26] The main donors of FP programs in Zambia are USAID, UNFPA, DfID, BMGF and IPPF, with USAID and UNFPA being the major financers of commodities specifically.

Supervision, Monitoring and Coordination

Since the reshuffling of family planning from MOH to MCDMCH in late 2011, FP activities have been difficult to coordinate. The MOH is responsible for commodities and provincial coordination, whereas MCDMCH is responsible for central policy-making, as well as district coordination. The FP division at MCDMCH has limited resources, and will need to be scaled up to ensure successful implementation of a new strategy. Current resources are pooled across topics, e.g., in maternal or reproductive health generally; and non-permanent positions are partner secondees.

The Family Planning Technical Working Group currently meets roughly quarterly to review topics related to FP, namely around policies and procedures needed from the government, rather than coordination of activities. The FP TWG includes a variety of donors, partners, private sector members and other branches of government. (See membership list in Annex D: Family Planning Technical Working Group Members

The implementation of activities or progress to date is not reviewed as part of the FP TWG meetings, except irregularly as new data is released (e.g., DHS). No national-level FP review or monitoring activities are conducted other than regular supervisory visits.

The Health Management Information System (HMIS), the facility data reporting system for the country, has been designed to provide user- and facility-level statistics on core indicators applicable to family planning. However, data is not always reported or entered into the system by health facilities. This is further complicated as some facilities handwrite reports and send them to the district, who do not enter the data into the system. Furthermore, the current data is not effectively used, as it is not necessarily analysed and reviewed regularly at existing meetings, to track progress or highlight concerns and issues.

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25 Bill & Melinda Gates Foundation. 2012. Zambia's Announcement at the London Summit on Family Planning: Dr. Joseph Katema, Minister of Community Development, Mother and Child Health for Zambia. Available at: http://www.youtube.com/watch?v=INXcgJSvsZ4

26 USAID DELIVER Zambia Family Planning Quantitative and Qualitative Logistics System Assessment, March 2008, Figure 18; AccessRH

Section 2: Integrated Family Planning Scale-Up Implementation Plan

Goal, Objectives and Strategic Priorities

Goal

The overarching goal of this Plan is to contribute to the reduction of maternal mortality and morbidity through scaling up the provision of quality integrated family planning services in Zambia in line with the Millennium Development Goals (MDGs), the Sixth National Development Plan 2011-2015 and the National Health Strategic Plan 2011-2015.

Objectives

Zambia's specific objectives are:

- To increase access to integrated family planning services and reduce the maternal mortality ratio (MMR) from 591 per 100,000 live births in 2007 to 159 by 2020;[27]
- To increase the contraceptive prevalence rate for modern methods from 32.7% to 58% by the year 2020[28] (women currently married or in union);
- To reduce unmet need for contraception from 27% in 2007 to 19% by 2015, and 14% by 2020; and
- To reduce teenage pregnancy from 28% in 2007 to 18% by 2020.

As part of the plan's development, strategic priorities have been identified that are critical to reaching these objectives in Zambia. These were developed by the MCDMCH with input from partners and an examination of the current family planning situation in Zambia.

Strategic Priorities (in no particular order):

1. **FP demand generation and behaviour change communication**: To strengthen demand for family planning services by repositioning FP as a key driver in development and providing targeted, easily-accessible and accurate information to the population.
2. **Adolescents and youth**: To more effectively target and serve adolescent and youth with quality accessible sexual and reproductive health information and services in and out of school.
3. **Staff and training**: To build capabilities of providers and increase the health system capacity to deliver high quality contraceptive services, including long-acting reversible contraceptives.

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27 National Health Strategic Plan 2011-2015, p. 47 (data are from 2009)

28 As pledged by the Minister of Community Development, Mother and Child Health at the London Summit on Family Planning. Bill & Melinda Gates Foundation. 2012. Zambia's Announcement at the London Summit on Family Planni ng: Dr. Joseph Katema, Minister of Community Development, Mother and Child Health for Zambia. Available at: http://www.youtube.com/watch?v=INXcgJSvsZ4

4. **Rural and underserved access to FP services**: To increase coverage and access to quality integrated FP services available to those living in rural and underserved urban areas.
5. **Stockouts at service delivery points:** To improve the distribution, availability and security of family planning commodities and associated consumables from the central level to service delivery points.
6. **FP governance structure and program coordination:** To strengthen the central, provincial and district-level FP structures to better coordinate and monitor government and partner activities, in order to deliver services efficiently.

Structure of the Plan

The activities in the plan are structured based on the six components of the framework used to examine Zambia's family planning context: demand, service delivery and access, procurement and supply chain, policy and environment, financing, and supervision, monitoring and coordination.

In these six categories, there are 29 total activities for implementing a full FP strategy in Zambia. Each of these is further detailed with sub-activities, and descriptions of each element for the plan's implementation. Furthermore, these correspond to output and outcome indicators for supervision and monitoring, and responsible parties for the activity's implementation. The full details of these activities can be found in Annex B: Implementation Framework with Full Activity Detail

Of all the activities included in the plan, some can be considered priority activities. Priority activities are those which directly support the strategic priorities identified. The remaining activities have been included based on identified needs, and as such, these activities support, complement and complete the family planning program in Zambia. In the case of a funding gap, the priority activities should be given precedence to ensure the greatest impact and progress towards the objectives laid out.

Demand

Justification

Public awareness in FP can be enhanced by increasing its public visibility. Knowledge and demand will come from wide dissemination of accurate information about FP methods and their availability, in addition to encouragement of FP use to promote the health of women and their families. Both advocates at the national level and locally trusted advocates can increase interest in FP within communities, producing a supportive environment, reducing normative barriers, and mobilizing community support.

Strategy

Key interventions proposed aim to sustain support for FP from the highest policy levels and promote public dialogue at all levels, from the national through to the community level, about the important role of FP in promoting health and supporting development. High-impact demand generation activities are included to close the knowledge-use gap by addressing myths and misinformation about FP and fear of side effects and health concerns that impede its adoption and use.

Specific demand generation efforts will be targeted at youth. FP education will be incorporated into the classroom setting, and teachers will be equipped to adequately support the sexual and reproductive health (SRH) needs of youth and adolescents. Peer educators shall be trained to help with information dissemination and linking young people to service delivery points if and when they need the services. Provision of adolescent and youth friendly services shall be mainstreamed into pre-service and in-service training of health care providers at all levels.

Activities

D1. Develop and roll out evidence-based, national, multimedia FP advocacy and demand generation campaigns *(priority activity – demand creation and behaviour change communication).* A national FP communications strategy will be developed. Based on this strategy, a national multimedia campaign, including television, radio and print media, will be rolled out. Key messages will include information on general FP promotion, selecting an FP method (e.g., short vs. long-term), dispelling false beliefs and myths about specific FP methods, and promoting male involvement. The strategy and messages will ensure that the majority of Zambians are reached, including those from vulnerable populations. Promotional and instructional materials will be produced for wide distribution at health care facilities and within communities. FP messaging will be integrated into ongoing health campaigns.

D2. Develop and deploy national- and community-level FP champions. A network of national FP champions will be established and maintained to promote FP. Two types of champions will be utilized: popular national figures who will promote the use of FP to the general public and community-level FP champions who will help to generate demand for methods by sharing information directly with potential users.

D3. Fully integrate FP/Sexual Reproductive Health (SRH) into school health program *(priority activity – adolescents and youth).* An adolescent SRH curriculum for grades 5-12 in public schools is currently under development and will be rolled out in 2014. Support will be provided for this roll out including training of teachers, revising training materials, and liaising with the Ministry of Education, Science, Vocational Training, and Early Education (MOESVTEE). Adolescent and youth sexual reproductive health (AYSRH) clubs, led by trained peer educators, will be established in secondary schools and colleges to support dialogue among adolescents and increase knowledge and awareness of family planning. Finally, youth development organizations will be briefed on the merits of including FP and SRH in their programming and will be linked with SRH partners who can provide support to include this programming

Service Delivery and Access

Justification

The current staffing, skill level and service structure within the Zambian health care system do not provide adequate and equitable FP services to the population. It is necessary both to bolster the current delivery system and to deploy new FP service approaches to optimize availability and accessibility.

Strategy

In order to ensure wide availability of FP, it is essential to identify what FP service delivery capabilities the health system has now and to develop systems to keep this knowledge current. The core of FP service availability is ensuring that FP health workers at each level have the appropriate training to provide FP services. Several innovative FP service delivery models have been successfully implemented by NGOs in Zambia. A government-owned and nationally-scaled version of these models has the potential to dramatically increase access. For example, current severe staff shortages of health care workers in Zambia make it very difficult to provide LARC as part of routine FP, but it has been demonstrated that dedicated FP providers using an outreach model can successfully provide LARC. Community-based distribution of certain FP commodities has also been successful at expanding access, and task-shifting of injectable contraception from nurses to CBDs has proved to be a safe, viable method for increasing availability. Other innovative approaches that optimize use of limited staff resources have similar potential for increasing FP availability and access and should be piloted and, if proven safe and effective, implemented.

To improve the family planning service delivery capacity in Zambia's resource-constrained setting, several strategies will be employed. A national, provincial and district level situation analysis will be conducted to determine the capacity, in terms of staff, staff training, equipment and supplies, to deliver FP services. This will be utilized as a guide for identifying gaps and directing resources.

FP training of health workers will be increased. A training plan will be developed based on the situation analysis of health worker skills. The training plan will undergo annual reviews to meet the country's human resource needs. Standardized curricula will be implemented, based on government support for curriculum review and enhancement of skills laboratories. All partners involved in training will work in coordination with the MDCMCH to reach training goals. In-service education will be scaled through a harmonized, decentralized and cost-efficient approach, including mentorship following formal training. Pre-service education will be strengthened so that providers entering the health care workforce are competent to provide all FP methods.

Task-shifting will be employed so that FP methods are available from the lower levels of the health system, relieving the burden at higher levels of care. Task shifting has been shown to help mitigate the human resource crisis in many countries, including Zambia. Included in this initiative will be expansion of community distribution of contraceptives.

Integration of FP into other health services is also a key strategy to enhancing the availability of FP. At higher level facilities with sufficient staff, FP services should be co-located with immunization services, providing a "one-stop shop" for women with small children who wish to delay or space births. Referral for FP services will be stressed in training and supervision of all health care workers who do not themselves provide FP.

The dedicated family planning provider (DFPP) model used by NGOs such as Society for Family Health and Marie Stopes International will be adopted on a national scale to provide family planning services at facilities where health care workers are too overburdened to regularly provide FP, especially LARC, through routine service provision. The DFPP model

will involve providing weekly, monthly or quarterly the full spectrum of non-permanent FP services at a facility, coinciding with under-5/immunization days at health facilities.

To enhance the provision of permanent FP methods, staff at hospitals will be trained to perform no-scalpel vasectomies and mini-laparotomies for female sterilisation. A program will be implemented to provide these services both at the hospitals and via outreach at health clinics.

To ensure that young women who have experienced unwanted pregnancies receive FP services, a program will be implemented to ensure that post-abortion care includes FP services.

Several other innovative approaches to enhancing FP availability will be piloted, including mini-clinics that will offer FP services in large urban markets and use of public/private partnerships.

Through these activities, the limited resources dedicated to FP will be maximized to reach rural and underserved populations. Although reaching these populations through a mix of service delivery clinics and community-based distribution may in some cases prove difficult and is usually more expensive than stand-alone clinic-based services, these initiatives help ensure more equitable access to FP services.[29]

Activities

SDA1. Evaluate current health system for FP capacity, establish mechanisms for ongoing capacity tracking and implement a mechanism for recommendations to be included in government and partner workplans and budgets. Mechanisms will be established to collect and evaluate information regarding FP capacity of each facility, including staff training status, equipment and NGO program presence.

SDA2. Develop and disseminate the in-service training plan and single standardized curriculum for each type of service provider and CBDs. A plan for FP training of Zambian health workers – in-service and pre-service – will be prepared. The various in-service training curricula and materials used in Zambia by GRZ and NGOs will be reviewed and standardized.

SDA3. Train the trainers for decentralization of FP service provision training to the provinces *(priority activity – staff and training).* A pool of FP trainers for nurses and midwives and for CBDs will be prepared in each province. Also included in this activity is procuring equipment required for trainings and instituting a pilot program using full-time trainers in place of the pool of trainers.

SDA4. Train current health providers in comprehensive FP with emphasis on LARC *(priority activity – staff and training).* Dedicated FP providers will be recruited and trained;

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29 A 2006 study found that community-based distribution programs cost from US$4.85 to US$35.37 per CYP, with a weighted average of US$12.55. Clinic-based services, excluding sterilisation, ranged from a cost of US$4.44 to US$16.65 per CYP, with a weighted average of US$7.93. A mix of access through clinics and community-based distribution is the most expensive mode of family planning service service delivery, ranging from US$4.44 to US$19.38, with a weighted average of US$18.21. (These study estimates do not include costs to users). Levine, R, A Langer, N Birdsall, G Matheny, M Wright, and A Bayer. 2006. Chapter 57: Contraception. In Disease Control Priorities in Developing Countries. 2nd edition. Eds. DT Jamison, JG Breman, AR Measham AR, et al. Washington (DC): World Bank; 2006.

nurses and midwives currently working where dedicated FP providers do or will do outreach will be trained and subsequently receive mentoring by the dedicated FP providers; all nurses who work in hospital ward which provide a significant amount of post-abortion care will be trained; and, eventually, all current nurses and midwives will be trained

SDA5. Improve pre-service training for FP by updating current curriculum *(priority activity – staff and training).* Pre-service curricula for nurses, midwives, doctors and clinical officers will be reviewed to ensure that they include adequate coverage of FP, including LARC and including appropriate levels of practical training

SDA6. Utilize a cadre of dedicated FP providers to improve FP provision capacity and provide mentoring of health care workers in FP. *(priority activity – rural and underserved access to FP services)* A dedicated FP provider outreach program will be instituted and managed by GRZ to ensure that all RHCs, UHCs and hospitals that cannot meet full FP demand (including LARC) with local staff are covered by such outreach service. GRZ will coordinate with NGOs which currently provide this service. These dedicated FP providers will also provide mentorship to local HCWs to enhance their FP skills, particularly after the local HCWs have received training as in SDA4.

SDA7. Standardize and scale up community based distribution of FP *(priority activity – rural and underserved access to FP services).* Standards for community based distributors – their selection, training and compensation – will be established. The community based distribution program, instituted and managed by GRZ, will be expanded through recruitment and training of new workers. Once fully approved, appropriately trained CBDs will provide injectable contraception.

SDA8. Expand access to FP services through new access points, including outreach, mini-clinics and public-private partnerships *(priority activity – rural and underserved access to FP services).* Access will increase with the establishment of GRZ-run permanent contraception services as periodic outreach to health centres from hospitals. There will also be piloting of periodic FP-only clinics at locations such as large urban markets where women congregate. MCDMCH and partners will explore opportunities to expand FP access within work settings.

SDA9. Leverage the expanding CHA program to improve community-level access to FP. The CHA scope of practice will be piloted, and if successful, expanded, to include implant insertion and removal, thus improving access to FP at the community level.

SDA10. Provide and maintain necessary FP equipment. An initial needs assessment will be conducted and regularly updated. Then, equipment that is needed will be procured for FP for each facility and for each FP program (e.g., dedicated FP providers, pilot mini-clinics).

SDA11. Integrate FP services with other health services. Standards for counselling and referral for FP services by providers of other health services will be established. Also included in this activity is integrating FP service provision into post-abortion care, particularly at hospitals which serve a large volume of post-abortion care patients.

SDA12. Provide targeted services and education to adolescents and youth *(priority activity – adolescents and youth).* Youth-friendly service points will be established in each district in existing government buildings such as sports complexes and administrative blocks. The rooms will be refurbished with FP materials and necessary supplies. Peer educators trained to dispense pills and condoms will staff the service points.

Procurement and Supply Chain

Justification

This category addresses the sustainable supply of contraceptive commodities and related consumables. It is aimed at ensuring that contraceptive commodities and related supplies are adequate and available to meet the needs and choices of family planning clients. The activities of this strategic priority will be implemented in line with the Reproductive Health Commodity Security (RHCS) Strategic Plan.

Providing a choice of family planning methods to meet the changing needs of clients throughout their reproductive lives increases overall levels of contraceptive use and enables individuals and couples to meet their reproductive goals. The method mix available influences not only successful client use and satisfaction, but also has implications for provider skills confidence and competence. In addition, specific activities will ensure that the contraceptives available in the country are of high-quality. Currently, significant distribution challenges are a limiting factor in ensuring the availability of high quality FP services at all levels of care. Specific activities will be undertaken to ensure that contraceptives are delivered through the "last mile" to the health facility to ensure RHCS throughout the country, including to rural areas.

Strategy

Because central level supply is not generally a significant challenge for family planning commodities, forecasting, quantification and procurement will continue as in recent years. However, as visibility into consumption patterns increases at lower levels of the health system, improved data is necessary to provide more accurate forecasting. Focus will be given to improving the distribution of commodities, ensuring the last mile of the supply chain is strengthened. As MSL assumes responsibility for forecasting, quantification, procurement and distribution all the way to the service delivery point, support will be provided to ensure that FP commodity supply remains secure and consistent.

Activities

PSC1. Forecast, quantity and procure FP commodities. Regular meetings will be held to carry out routine processes for forecasting, quantification and procurement of commodities. Co-packing consumables with commodities will be explored.

PSC2. Assure the quality of contraceptives. Quality assurance testing will be conducted on contraceptives to verify the quality of the commodities.

PSC3. Build FP commodity logistics capacity at all levels. 2,000 health care workers will be trained in logistics management by 2015; another 1,000 HCWs will be trained by 2020.

PSC4. Ensure last mile distribution of contraceptives to facilities not currently reached directly by MSL *(priority – procurement and supply chain).* The decentralization of the MSL distribution system will be supported. In facilities not yet reached by the new MSL system, financial support will be provided to procure vehicles necessary for last mile distribution. The RH Logistics Coordinator will track commodity requests and distributions closely, following up with facilities on an individual basis where there are challenges.

PSC5. Proactively identify and address challenges with distribution and requisition of FP commodities. The RH Logistics Coordinator will conduct a mapping of commodities at every level of the supply chain, identifying and addressing bottlenecks in real time and following up with facilities that are not requesting or using particular commodities.

PSC6. Support partners in FP commodity procurement and distribution. A new process for accessing commodities from MSL will be developed to so that partners can quickly and efficiently receive and distribute their stock.

Policy and Environment

Justification

Although FP has been recognized in policy as a key element to improving national health and development, the full implementation of FP activities has not been prioritized by the GRZ through the allocation of human and financial resources necessary. Therefore, this category of policy and environment focuses on advocacy for FP within various levels and sectors of the government to ensure the right policies are not only present, but are also fully implemented.

Strategy

To improve the policy environment for family planning, government policies and strategies will be reviewed to ensure that FP is integrated appropriately. The MCDMCH and partners will ensure that FP is integrated into the preparation and review processes of national health and development processes. Specific advocacy will also be conducted to ensure that policies and guidelines for FP promote access to FP rather than hamper access for often-marginalized groups such as the rural population and youth. For example, the FP guidelines will be revised to give health care providers clarity on how to counsel and provide services to adolescents less than 16 years of age. The community-based distribution of injectables pilot has provided local evidence that task-shifting for injectable distribution is not only safe, but also effective in expanding access to FP for rural communities. Policy revisions will allow scale-up of CBD of injectables throughout Zambia. In addition, the MCDMCH and partners will create and support nation-level advocates who can play a key role both publically and behind-the-scenes in ensuring that FP remains in the limelight for the GRZ in both policy and domestic funding.

Activities

PE1. Include FP in relevant national policies. A review will be undertaken of existing policies to ensure that relevant FP issues are adequately addressed, and any necessary changes will be advocated for and incorporated.

PE2. Create a consortium of advocates for FP. In addition to the network of national FP champions and promoters, FP advocates will advocate within government to emphasize the important of FP, especially as related to policies and budgeting.

PE3. Revise the FP guidelines to address task-shifting and under 16 access. Policies will be reviewed and revised to allow provision of contraceptives to adolescents under the age of 16. Policies will also be reviewed and revised so that the lowest cadres of health care workers can deliver appropriate contraceptives at the community level. A successful pilot of community-based distribution of injectables, as well as evidence from programs in other

countries, will provide the basis for allowing CBDs to provide this FP method. In addition, policy revisions will allow CHAs to provide implants based on evidence from successes in other countries.

Financing

Justification

While the overall policy environment for FP is positive through the incorporation of FP/RH into the GRZ's development and health frameworks, the government's strong policy and strategy commitment has not been accompanied by equally commensurate dedication of national financial resources.

Strategy

To address the limited financial commitment to FP within the GRZ budget in commensurate to need, the MCDMCH and partners will advocate for increased funding within national budgets, in addition to funding secured from development partners. MCDMCH will also cultivate advocates within other ministries, as well as within parliament, to ensure that the national budget includes a line item for FP, which is increased over time, to meet the growing demand for FP services in the country as BCC and FP access activities roll out over the next eight years.

Activities

F1. Advocate for increased funding for FP, from the government and donors. Advocacy meetings will be held with government stakeholders, including MOF, as well as with current and interested partners to secure the necessary financing for the completion of this plan, ongoing FP activities, and the financing of FP commodities, including increasing the budget line.

Supervision, Monitoring and Coordination

Justification

Effective management and governance of family planning activities at all levels is needed to ensure family planning goals are reached. Better systems are needed to improve coordination among partners and the MCDMCH and ensure activities are implemented as a harmonized national effort. Current bottlenecks in supervision, monitoring and coordination include limited dedicated staffing resources at national and district levels. As such, the staff managing FP activities are also often responsible for a variety of other maternal health activities and are thus overburdened with responsibilities they are unable to effectively manage due to limited time. In addition, a lack of clear systems and processes to supervise, monitor, track and coordinate government and partner activities at the national and decentralized levels has hampered the overall management of FP activities in Zambia.

Strategy

To enhance the management of family planning activities, a new RH Specialist will be placed at the MCDMCH to act as a central lead for FP and the overall coordinator of the FP plan's implementation. This person will lead a team of FP staff at the central level to manage and coordinate implementation of the Eight-Year Plan; in addition to the existing FP resources

and PPAZ/ZISSP-seconded FP Specialist, these will include new government resources: a Chief FP Officer, responsible for LARCs and the training program and a Principal FP Officer, in charge of community outreach and integration, as well as the CBD program. In addition, the MNCH division will be reinforced with a government RH Logistics Coordinator, whose role includes ensuring the distribution of contraceptives and FP consumables by coordinating with the district pharmacists. These resources are in addition to any of any new partner-seconded resources.

For provincial and district-level FP coordination, FP focal points will be appointed to enhance management on the ground. Currently, MNCH Coordinators at both the provincial and district-level are responsible for a number of activities, including FP. At the provincial level, a non-clinical resource other than the MNCH Coordinator will be trained to take on FP as part of their role. At the district level, new resources will be hired to coordinate two MNCH topics, one of which will be FP. Most of these resources will need to be seconded resources from partners, and so their roles will often be combined with the other objectives of the partners' programs, e.g., eMTCT or adolescent SRH. The presence of new FP coordinators will enable a more focused effort at the local level due to their more narrow terms of reference, with specific dedication of 50% of their time to FP.

The Family Planning Technical Working Group (FP TWG) is a critical body for coordinating partners and managing work at the central level. Efforts will be undertaken to make the TWG more effective and efficient, by ensuring a standardized schedule of meetings and list of meeting attendees.

Existing data collection, supervision and monitoring tools will be revised and new tools will be developed to closely track a revised list of HMIS FP indicators. An executive dashboard will be developed to easily track progress across the key FP indicators at a central level and to monitor progress on the Eight-Year Plan. The dashboard will be tracked as part of regular FP TWG meetings.

A simplified roadmap (*in Annex A: M&E Tools*) will be used by MCDMCH at the central level as a supervisory tool to ensure the activities in the plan are progressing as outlined. Semi-annual review meetings at the central level, and quarterly review meetings at the provincial and district levels, will be held to review progress on activities. Supervisory visits at every level, nationally through to the CBD level, will help inform this progress.

In addition, the plan's objectives will be revised after the release of the Zambia DHS survey, expected in 2014 and 2019. In mid-2017, there will be a mid-term plan review to determine the progress so far and determine how to adjust activities moving forward. The post-2019 DHS review will serve to determine whether the plan has been effective, and be used as a base to inform Zambia's family planning strategy post-2020.

Mentorship and supervision are key strategies for improving quality of implementation. Supervision tools will be revised to include key FP quality standards, such as youth-friendly service provision, Supervisors will receive training in conducting supportive supervision visits. Mentoring tools for FP will be developed as part of the training curriculum for use in post-training mentorship sessions.

Activities

SMC1. Enhance the governance structure for improved management of FP at every level of the national health system *(priority activity – FP governance structure and program coordination).* Additional resources will be hired to the FP division, and provided them with the necessary equipment for ongoing operations. The coordination of FP activities will be improved at the national level with institutionalized FP TWG meetings and at the provincial and district levels with dedicated coordinators.

SMC2. Develop supervision tools, including data collection tools and a dashboard. Data collection tools will be developed to ensure adequate data is collected from service delivery points, including from partners. This data will then be summarized in a dashboard for monitoring.

SMC3. Conduct supervisory visits of FP activities. Supervisors will be trained to conduct supervisions of FP activities from the central level down to service delivery points on a regular basis.

SMC4. Regularly review plan progress and scale up successes *(priority activity – FP governance structure and program coordination).* The progress of the plan will be monitoring and adjusted as needed, with regular meetings at the central, provincial and district levels; a larger mid-term plan review will occur in 2017 and when DHS results are released.

Section 3: Costing

Assumptions

The method mix used to estimate the costs of contraceptives are based on the same inputs as those calculated by Marie Stopes International (MSI)'s Impact 2 Model in Section 4: Projected Method Mix, Contraceptive Needs, and Impacts.

These contraceptive costs are calculated from 2013 to 2020, based on the current (2013) estimated and 2020 objective MCPR for all women of reproductive age, extrapolated for each intermediate year.

These inputs should be updated when the DHS data comes out in 2014 for a new base; and the objectives should be updated if these are changed.

Costing elements are described and costed based on knowledge of similar FP programs in other countries, and input from MCDMCH and partners as to specifics in Zambia (e.g., number of trainers required per training). All of these inputs are editable in the costing tool, if needed. In particular, costs for standardized meetings or trainings can be entered, including overhead costs such as room rental, per diems for facilitators and attendees, tea and lunch, travel, and document printing. Each activity's costing inputs, for both unit costs and quantities can be changed, e.g., the cost of producing a radio program, the number of programs to be produced, the cost of broadcasting the program, and the number of times it will be broadcast.

Costing inputs have come from a variety of sources, and include standards from MCDMCH, partner budgets, true quoted costs (e.g., from the radio stations and from the Government Printing Department). Where specific costs were not available, estimates from other countries have been adjusted for Zambia. Commodity costs, for both contraceptives and consumables, come from AccessRH (although this is not used for procurement in Zambia).

Unless otherwise noted, all consumable costs (such as salaries, per diem rates, fuel costs, venue hire, etc.) are based on current costs as of August 15th, 2013, and have not been adjusted for inflation over time or currency fluctuations. The inputs can be updated yearly to take these into account if needed. All costs have been calculated in ZMW, and the cost breakdown at provincial level is based on the geographical map of Zambia as of 2010.

District-level activities, namely the dedicated family planning providers (SDA6) and the district-level FP coordinators (SMC1.3) have been calculated with a provisional list of 72 districts, although the current number of districts is closer to 100. For these activities, a population-based approach should be used rather than a district-based approach, as district boundaries change throughout the course of the plan. One FP coordinator or one dedicated midwife may cover only a part of one district, or many districts, depending on the population size and geographical distribution. These do not need to be distributed the same way.

Furthermore, it is expected that all pre-service and in-service training costs will be revised once the training plan is complete, as innovations in training or the timing of training may change.

All activities currently ongoing in regards to FP in Zambia are considered to be owned by the GRZ, and therefore have been costed in this plan, Some of these activities (especially for 2013 and 2014) have already received donor commitments, however they are nonetheless still included in the total budget (although the partner committed has been noted in the Implementation Matrix under the "responsible" column). Following the dissemination of the plan, a stakeholder buy-in will be conducted in order to identify additional plan activities which may be supported by partners as the plan is rolled out, and a gap analysis will be conducted at that time in order to identify which activities are still un-(or under)-funded.

The costing tool is available from MCDMCH for review, updating, or modification for other programs.

Cost summary

The costs of this plan have been specifically calculated using a tool developed for this purpose, with methodology borrowed from other Family Planning plan costings regionally. The tool allows for a calculation of the overall costs of the plan, as well as a split of the costs by activity area, province, and year. It includes both initial (investment) costs and ongoing or sustainability costs, for the duration of the plan. However, this should only be considered a broad costing of the plan, not a budgeting tool to be used on an activity-by-activity basis to allocate funds.

The total costs of the plan, from 2013-2020, are 591 million ZMW (rebased), roughly equivalent to 109 million USD.

Overall, 208 million ZMW, or 35% of the overall costs are in commodities, including contraceptives and consumables. Another 29% are in service delivery and access, 22% in supervision, monitoring and coordination, and 12% in demand creation. Procurement and supply chain, policy and environment, and financing, make up the remaining costs at <2% of the total.

Table 3: Costs of the Scale Up Plan by activity area

ANNUAL COSTS									
Costs in ZMW	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**TOTAL**
Demand	2,982,040	15,684,228	5,298,270	5,423,250	15,280,859	4,923,579	5,048,559	15,280,859	69,921,646
Service delivery and access	6,488,949	34,858,580	23,609,639	21,732,201	22,927,973	20,978,407	20,044,644	23,127,378	173,767,771
Procurement and supply chain	1,276,965	1,307,235	1,280,218	1,159,802	1,161,608	1,163,490	1,165,450	1,167,491	9,682,260
Policy and environment	118,201	114,272	53,555	98,555	53,555	216,756	53,555	53,555	762,005
Financing	95,454	53,829	-	53,829	-	53,829	0	53,829	310,771
Supervision monitoring and coordination	12,679,381	19,172,867	15,356,531	19,586,134	14,720,264	18,152,101	14,492,340	14,422,498	128,582,114
FP commodities	19,331,548	21,062,874	22,877,497	24,778,729	26,769,999	28,854,859	31,036,990	33,320,202	208,032,697
Grand Total	**42,972,538**	**92,253,885**	**68,475,711**	**72,832,501**	**80,914,257**	**74,343,021**	**71,841,538**	**87,425,812**	**591,059,264**
Total in USD	7,957,877	17,084,053	12,680,687	13,487,500	14,984,122	13,767,226	13,303,989	16,189,965	109,455,419

Costs are spread over the duration of the plan, with commodity costs increasing over time as more women are reached. There are heavier upfront investments in training and communications, in particular in 2014 as many of the activities have initial investments. The activities supporting the strategic priorities make up 44% of the plan's total costs, with the biggest cost driver being in rural and underserved access to FP services, and demand generation and behaviour change communication activities, at 13.1 million and 7.8 million ZMW annually on average. Staff and training and the FP governance structure are the next most expensive strategic priorities. These are priority activities for funding as they directly support the strategic priorities, necessary to ensure the successful implementation of the plan.

The costs of the plan are comparable to other similar Family Planning plans. The cost per woman of reproductive age for activity costs (cost of the plan without commodities, 383 million ZMW) is 13.05 ZMW; which is in line with costs in other countries of ~11-27 ZMW (~$2-5 USD). The cost per user for FP commodities (total of 208 million ZMW) is 19.29 ZMW, a bit lower than the costs of 21-23 ZMW ($4-4.20 USD) seen in other countries. This is likely due to the higher expected uptake of (cheaper) long-acting methods, combined with the current price reductions in implants, which were not yet in effect in previous country plans.

Chart 2: Costs by category and strategic priority – The plan will cost a total of 591M ZMW, with the highest costs other than commodities in service delivery and access

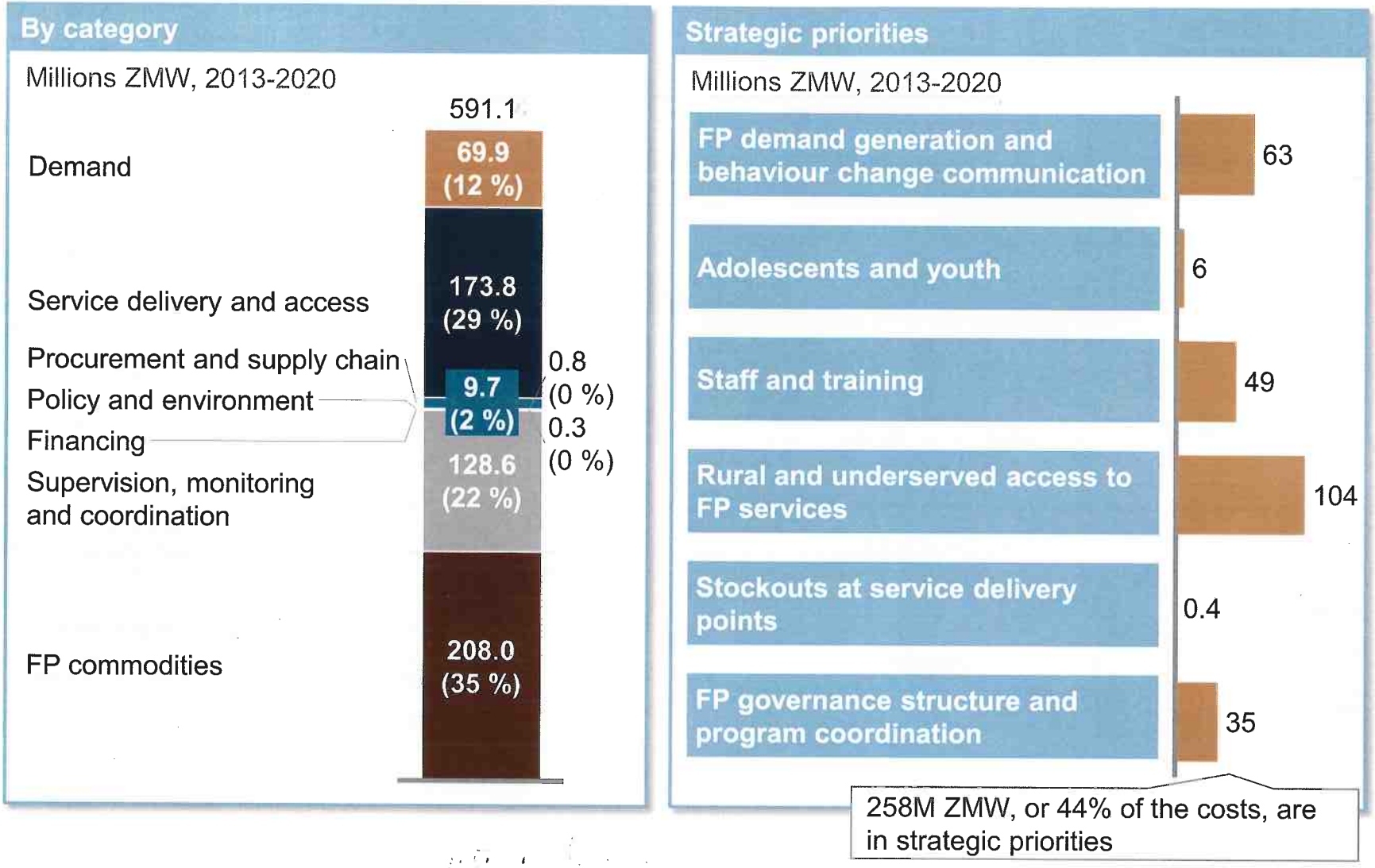
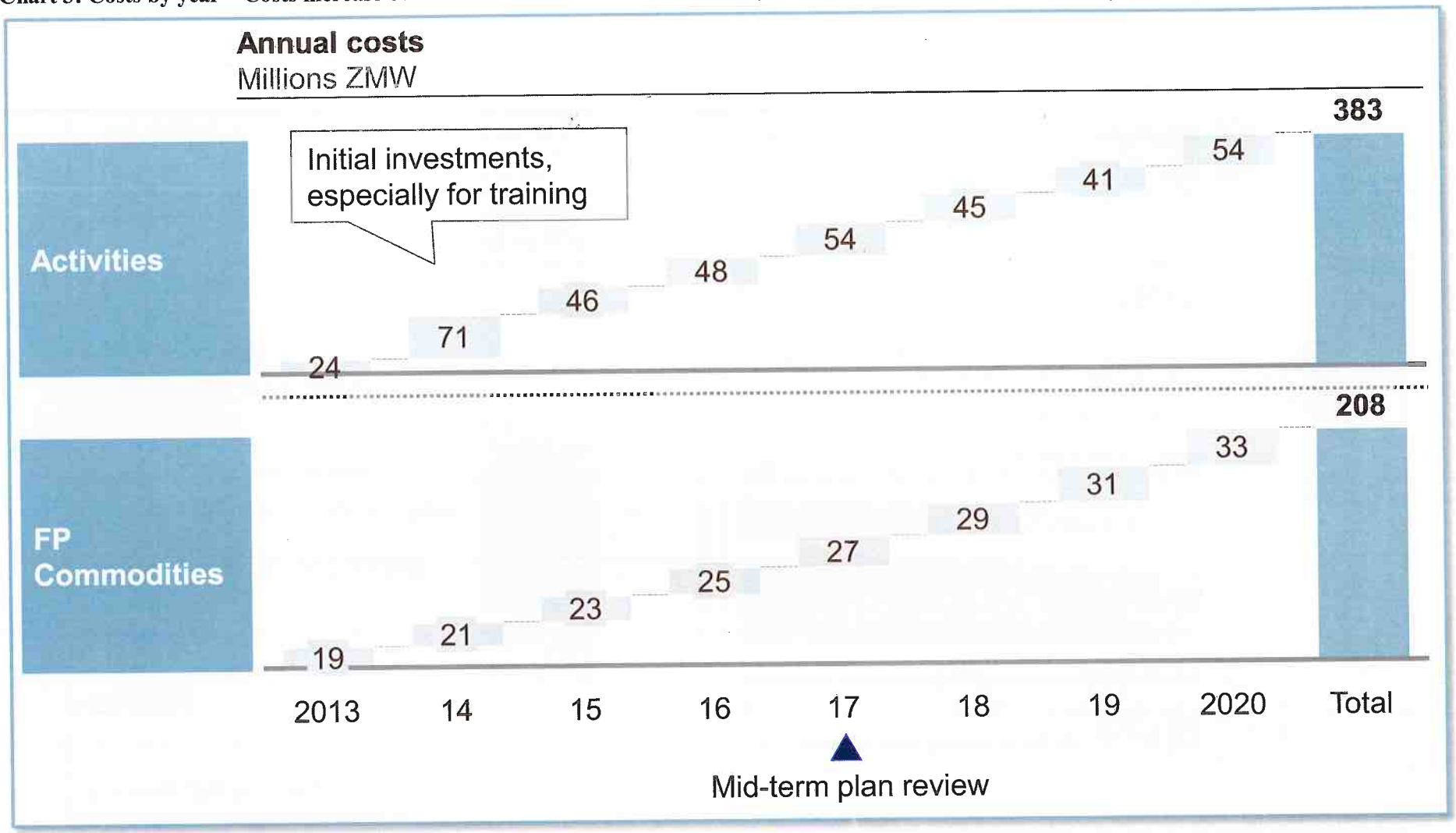


Chart 3: Costs by year – Costs increase over time as more women are reached, with heavier upfront investments in training



Section 4: Projected Method Mix, Contraceptive Needs, and Impacts

The interventions of this FP Scale-Up Plan will lead to reaching 912,255 new users of contraception, with 516,201 implants, 88,165 IUDs, 14,681,269 injectables, 31,737,967 pill cycles, and 55,976 with permanent family planning methods between 2013 and 2020, leading to an increase in CPR for modern methods from the current 32.7% to 58% by the year 2020.[30] This is a total 1,827,581 women users of contraception in 2020.

MSI's Impact 2 Model[31] was used to calculate the impacts that the Republic of Zambia will benefit from by increasing MCPR to 58% by 2020. These demographic, health and economic impacts include:

- Unintended pregnancies averted;
- Abortions averted;
- Unsafe abortions averted;
- Maternal deaths averted;
- Child deaths averted (due to improved birth spacing);
- Healthcare costs saved (ZMW); and
- Total CYPs.

These calculations estimate that the FP interventions in Zambia will avert 3,519,126 unintended pregnancies, 479,559 unsafe abortions, and 9,924 maternal deaths between 2013 and 2020. The services provided over the eight years will lead to 10,754,065 couple years of protection (CYP). Additionally, the intervention will lead to saving 1.493 billion ZMW during the eight-year project period.[32]

These impacts were calculated by estimating the current MCPR for all women for modern methods, and inputting method mix assumptions for the baseline year of 2012, based on 2007 DHS data as well as the true 2010-2012 commodity issues in Zambia. The method mix used is roughly an average of the two data sets, which is suitable until a more recent DHS is released. A target method mix for 2020 was projected by the TST, based on the following assumptions and guided by recommendations made by members of the FP Working Group:

1) The FP Scale-Up Plan will be fully implemented by MCDMCH and partners, including specific emphasis on reaching underserved women, such as rural populations, urban poor, and youth, and creating demand and improving access for LARCs.

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30 2013 Calculations by TST using Marie Stopes International. Impact 2. 2013.

31 Marie Stopes International. 2013. Impact 2.

Weinberger M, Pozo-Martin F, Boler T, Fry K, and Hopkins K. Impact 2: An innovative tool for estimating the impact of reproductive health programmes—methodology paper. London: Marie Stopes International, 2012.

32 Marie Stopes International. 2013. Impact 2.

2) LARCs will rise at a similar rate to other countries in the region based on similar data for demand and access[33] once LARCs are available at more service delivery points and demand-creation activities for LARCs have begun. The greatest rise in LARCs will be for implants, accompanied by an increased demand for IUDs, though at a lower rate.
3) Injectable use will increase in line with similar rises in other countries in the region due to increased access resulting from planned policy change to allow task-shifting for injectable provision by CBDs, and in line with historical increase in injectable uptake.[34]
4) Pill use will decrease slightly as a percent of all methods used, due to improved access to injectables and LARCs.[35]
5) The use of condoms as a primary form of contraception will decrease.
6) The calculated number of women using LAM will decrease, as the high figures in the Zambia 2007 DHS are inconsistent with clinical studies reporting that the number of women who use LAM correctly in Zambia is 20%[36]. Thus, the forecast in the number of women attaining contraceptive coverage due to LAM decreases.

The 2012 baseline method mix assumptions and the 2020 objective method mix assumptions, for all women, are outlined below.

Table 4: Baseline method mix (2012) vs. issues data and DHS method mix, for all women

Contraceptive method	Implied method mix		Suggested method mix
	Issues data (2010-2012)	DHS 2007	Baseline (2012)
Pills	15.5%	30.1%	**21.5%**
Injectables	38.9%	25.2%	**30.0%**
Condoms (male)	29.1%	20.3%	**27.5%**
Condoms (female)	0.7%	0.0%	**0.4%**
Implants	7.9%	1.2%	**6.0%**
IUDs	2.3%	0.4%	**2.0%**
Female ster.	1.4%	5.7%	**4.0%**
Male ster.	0.0%	0.0%	**0.1%**
Other (includes LAM)	4.1%	17.1%	**8.5%**

33 ICF International, 2012. MEASURE DHS STATcompiler. Available at: http://www.statcompiler.com. Accessed on July 22 2013.

34 ICF International, 2012. MEASURE DHS STATcompiler. Available at: http://www.statcompiler.com. Accessed on July 22 2013.

35 ICF International, 2012. MEASURE DHS STATcompiler. Available at: http://www.statcompiler.com. Accessed on July 22 2013.

36 Short Fabica, M, Choia, Y. 2013. Measuring Use of the Lactational Amenorrhea Method through the Demographic and Health Surveys: Data Quality and Implications. Presentation at the 2013 PAA annual meeting. Population Association of America. Available at: http://paa2013.princeton.edu/papers/131146

Table 5: Objective method mix (2020), for all women

Contraceptive method	Suggested method mix
	Objective (2020)
Pills	**21.0%**
Injectables	**33.0%**
Condoms (male)	**15.0%**
Condoms (female)	**0.2%**
Implants	**18.0%**
IUDs	**4.0%**
Female ster.	**5.0%**
Male ster.	**0.3%**
Other (includes LAM)	**3.5%**

Details of the annual method mix, services/commodities, contraceptive prevalence by methods, and demographic and health impacts are shown in Tables 6, 7, 8 and 9 below. Note that for condoms, pills and injectables, the numbers in Table 6 represent the number of commodities (condoms, pill cycles, and injections) and not the number of users.

Table 6: Method mix of FP users served each year

METHOD	2013	2014	2015	2016	2017	2018	2019	2020
Long-Acting and Permanent Methods (LAPM)								
Female Sterilisation	0.5%	0.5%	0.5%	0.5%	0.6%	0.6%	0.6%	0.6%
Male Sterilisation	-	-	-	-	-	-	-	-
Implant- 5 year	2.6%	3.2%	3.8%	4.4%	5.0%	5.7%	6.4%	7.1%
IUD- 10 year	0.5%	0.6%	0.7%	0.8%	0.8%	0.9%	1.0%	1.1%
Short-term methods								
Male Condoms	29.1%	27.7%	26.4%	24.9%	23.5%	22.0%	20.4%	18.8%
Female Condoms	0.4%	0.4%	0.4%	0.4%	0.3%	0.3%	0.3%	0.3%
Pills	24.0%	24.3%	24.6%	24.9%	25.3%	25.6%	26.0%	26.3%
Injectables	34.0%	35.0%	36.0%	37.0%	38.0%	39.1%	40.2%	41.4%
LAM	8.8%	8.2%	7.7%	7.0%	6.4%	5.8%	5.1%	4.4%

Table 7: Services and Commodities Provided by Year[37]

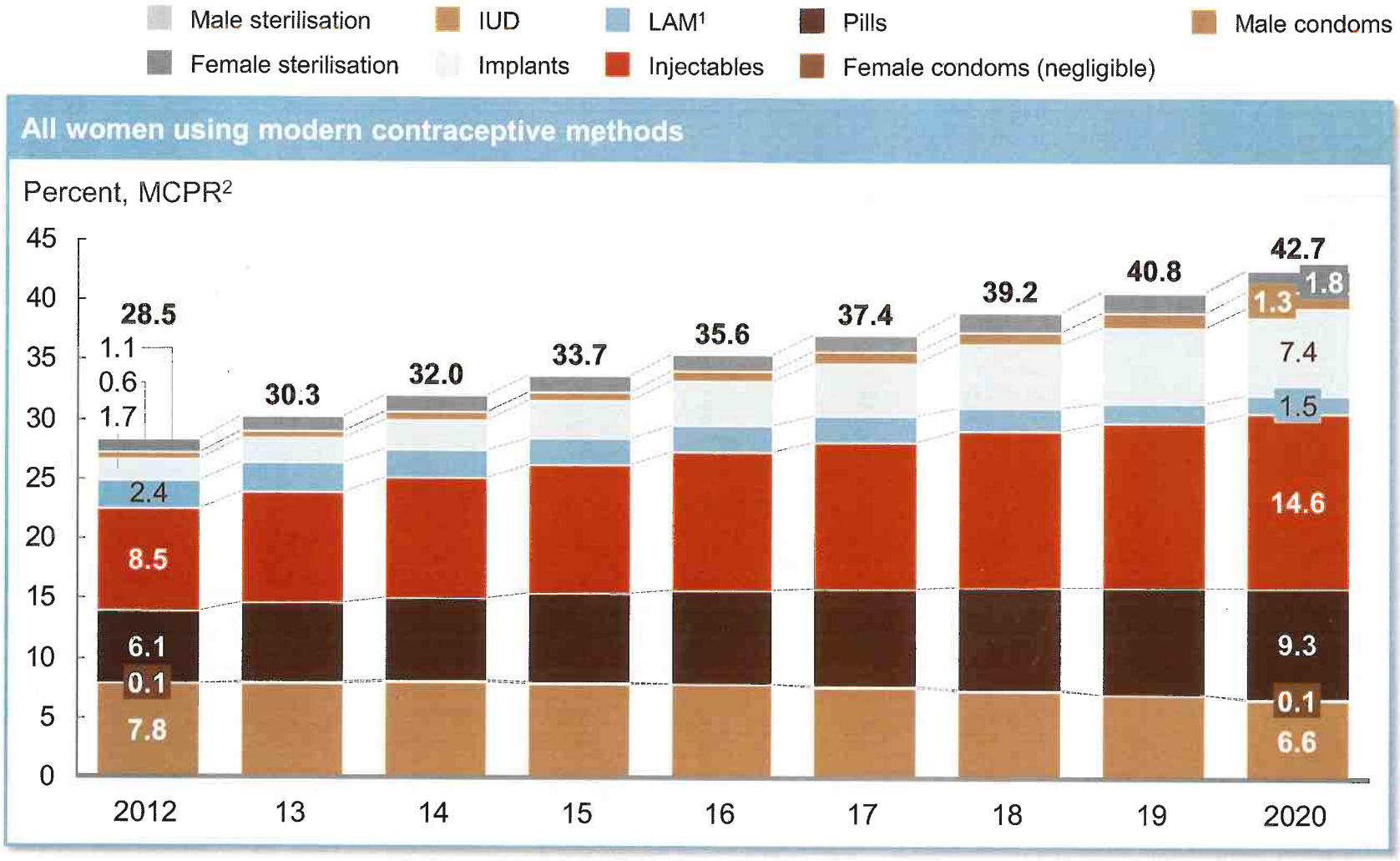
	2013	2014	2015	2016	2017	2018	2019	2020
LAPM								
Female Sterilisation	4,226	4,826	5,478	6,177	6,926	7,716	8,567	9,474
Male Sterilisation	128	170	219	275	337	406	483	568
Implant- 5 year	25,534	33,972	43,698	54,766	67,231	81,060	96,455	113,484
IUD- 10 year	5,426	6,684	8,106	9,698	11,464	13,397	15,527	17,863
Short-term methods								
Male Condoms	25,937,557	27,025,537	27,886,326	28,486,435	28,798,723	28,769,947	28,438,798	27,777,922
Female Condoms	375,001	388,059	397,285	402,161	402,268	396,827	386,338	370,372
Pills	2,843,756	3,143,787	3,455,971	3,778,813	4,111,305	4,448,105	4,797,473	5,158,757
Injectables	1,239,799	1,391,582	1,552,965	1,723,549	1,903,123	2,089,415	2,286,492	2,494,344
LAM	80,357	82,024	82,638	82,074	80,230	76,936	72,274	66,138

Table 8: Contraceptive Prevalence by Method (all women)

METHODS	2012 (Baseline)	2013	2014	2015	2016	2017	2018	2019	2020
LAPM									
Female Sterilisation	1.1%	1.2%	1.3%	1.4%	1.4%	1.5%	1.6%	1.7%	1.8%
Male Sterilisation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%
Implant	1.7%	2.1%	2.5%	3.1%	3.8%	4.5%	5.4%	6.3%	7.4%
IUD	0.6%	0.6%	0.7%	0.7%	0.8%	0.9%	1.0%	1.2%	1.3%
Short-term methods									
Male Condoms	7.8%	7.9%	8.0%	7.9%	7.8%	7.6%	7.3%	7.0%	6.6%
Female condoms (Negligible)	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
Pills	6.1%	6.6%	7.0%	7.4%	7.8%	8.2%	8.6%	8.9%	9.3%
Injectables	8.5%	9.3%	10.0%	10.8%	11.6%	12.3%	13.1%	13.8%	14.6%
LAM	2.4%	2.4%	2.4%	2.3%	2.2%	2.1%	1.9%	1.7%	1.5%
Any modern method	28.5%	30.3%	32.1%	33.8%	35.6%	37.4%	39.2%	40.9%	42.7%

37 This is the estimated number of services by method that would need to be provided in order to reach the FP goal. These have been calculated based on the total users needed to reach the goal, continued use of LAPMs from baseline use (from historic services or CPR), and method-specific discontinuation. The results are dependent on the method mix of services set for each year.

Chart 4: Modern contraceptive prevalence for all women, by method



1 Includes LAM = Lactational Amenorrhea Method, only considered a modern method since the 2007 DHS
2 May not sum due to rounding

Table 9: Annual Impacts of the FP Scale-up

	2013	2014	2015	2016	2017	2018	2019	2020
Couple Years of Protection (CYP)	904,425	1,016,244	1,135,306	1,261,303	1,394,105	1,532,061	1,678,184	1,832,435
Demographic impacts								
Unintended pregnancies averted	299,961	333,498	370,041	409,772	452,900	499,720	549,890	603,343
. . . of which are among teenagers (15-19)	65,550	72,878	80,864	89,546	98,971	109,202	120,166	131,847
Abortions averted	42,686	47,459	52,659	58,313	64,450	71,113	78,252	85,859
Health impacts								
Maternal deaths averted	846	941	1,044	1,156	1,277	1,409	1,551	1,702
Child deaths averted*	8,880	9,873	10,954	12,131	13,407	14,793	16,278	17,861
Unsafe abortions averted	40,876	45,447	50,426	55,841	61,718	68,098	74,935	82,219
Economic impacts								
Healthcare costs saved (millions, ZMW)	127.2	141.4	156.9	173.8	192.1	211.9	233.2	255.9

Annex A: M&E Tools

List of HMIS indicators to track

Monitoring and evaluation tools for this FP plan should not be developed independently of existing tools for the health system in Zambia to ensure sustainability, relevance and ease of use by healthcare workers who must enter the data. The current Health Management Information System (HMIS) tracks several service delivery indicators in healthcare at the facility, district and province levels. These already include safe motherhood and family planning indicators. SmartCare tracks patient records in select facilities, including FP use and method.

Indicators related to family planning are already included in the HMIS system and tracked monthly at the facility level. Current indicators are listed below:

- Attendance safe motherhood (Number of women receiving counseling on safe motherhood)
- Attendance family planning (Number of women receiving counseling or services in family planning)
  - New
  - Revisit
- Family planning methods distributed or administered (Number of women receiving the service in each type of method or quantity of product distributed)
  - Male condoms distributed
  - Female condoms distributed
  - Oral pill cycle (COC)
  - Progesterone only pill (COP)
  - Medroxyprogesterone injection (3-month injectable)
  - Norethisterone enanthate injection (2-month injectable)
  - Implant
  - IUCD inserted
  - Sterilisation female
  - Sterilisation male

Existing HMIS indicators are sufficient to track progress of the plan in terms of users, but the issue lies in that they are not always reported or entered into the system by health facilities. This is further complicated as some facilities handwrite reports and send them to the district, who do not enter the data into the system. Furthermore, the current data is not effectively used, as it is not necessarily reviewed regularly at existing meetings, to track progress or highlight concerns. These issues are addressed in activities in Supervision, Monitoring and Coordination in the plan.

Find below a tentative list of HMIS indicators to include/update as part of the next HMIS review. These are defined keeping in mind what can easily be tracked and reported on at the

facility level, for analysis at a higher level. These would be very valuable in tracking the progress of the family planning program, and better understanding the needs of users (e.g., these could be used in forecasting commodities). The list is tentative but not necessarily complete, as other indicators or ideas may be added over time based on what is suggested by MCDMCH and partners during regular review meetings. If DHIS2 is rolled out, these indicators should be considered for integration into the new system. These meetings will also focus on the number of facilities reporting data. The suggested indicators are:

- Percentage of facilities reporting data (Number of facilities reporting / Total number of facilities)
- Attendance safe motherhood (Number of women receiving counseling on safe motherhood)
- Attendance family planning (Number of women receiving counseling or services in family planning)
  - New
  - Revisit
- Family planning methods distributed or administered (Number of women receiving the service in each type of method or quantity of product distributed)
  - Male condoms distributed
  - Female condoms distributed
  - Emergency contraceptive pills distributed
  - Oral pill cycle (COC)
  - Progesterone only pill (COP)
  - Medroxyprogesterone injection (3-month injectable)
  - Norethisterone enanthate injection (2-month injectable)
  - Implanon implant inserted
  - Sinoplant implant inserted
  - Jadelle implant inserted
  - IUCD inserted
  - Sterilisation female
  - Sterilisation male
- Family planning methods distributed by CBDs (Quantity of product distributed by CBDs associated with the health centre)
  - Male condoms distributed
  - Female condoms distributed
  - Oral pill cycle (COC)
  - Progesterone only pill (COP)
  - Medroxyprogesterone injection (3-month injectable)
  - Norethisterone enanthate injection (2-month injectable)

- Family planning methods removed (Number of women receiving the service in each type of method)
  - Implanon implant removed
  - Sinoplant implant removed
  - Jadelle implant removed
  - IUCD removed
- Of family planning methods distributed, those distributed to adolescents (15-19 years) and youth (20-24 years), for each method
- [recommended but not necessary] Referrals to higher levels of care for FP services (Number of women counseled on FP, choosing a method not available at this facility, in each type of method)
  - Injectable (referred by CBDs)
  - Implant
  - IUCD
  - Sterilisation female
  - Sterilisation male
- [recommended but not necessary] Referrals to family planning from other health services (Number of women who came in for services or counseling on another topic but were also counseled in FP)
  - HIV/AIDS
  - Post-partum services
  - Post-abortion care
  - Under-5 immunization
  - Other (e.g., pre- and post-natal care, male circumcision, cervical cancer screening, gender based violence, and STI management)
- [recommended but not necessary] Number of users coming from referrals to family planning from other health services (Number of referred women accepting and receiving FP commodities after counselling)
  - HIV/AIDS
  - Post-partum services
  - Post-abortion care
  - Under-5 immunization
  - Other (e.g., pre- and post-natal care, male circumcision, cervical cancer screening, gender based violence, and STI management)
- [recommended but not necessary] Stock-outs of family planning commodities (Number of days with no facility stock in each type of method) *Note that this is separate from stock data and orders which are tracked by MSL
  - Male condoms
  - Female condoms
  - Emergency contraceptive pills

- Oral pill cycle (COC)
- Progesterone only pill (COP)
- Medroxyprogesterone injection (3-month injectable)
- Norethisterone enanthate injection (2-month injectable)
- Implanon implant, if applicable to that facility
- Sinoplant implant, if applicable to that facility
- Jadelle implant, if applicable to that facility
- IUCD, if applicable to that facility

From these suggested indicators, districts, provinces or the central level will be able to fairly accurately estimate the current MCPR (based on attendance, methods distributed, methods distributed by CBDs and methods removed). Additional data on removals will highlight issues with LARCs; with referrals from other health issues the integration of FP with other health services; and with stock-outs and referrals to higher levels of care, any issues in the supply chain and method availability.

Dashboard

The executive dashboard is a tool for monitoring the progress on the plan. The outcome indicators included come from a variety of sources, and so new information will not be available for every indicator quarterly (e.g., data from the DHS is only released every 5 years). Partners are expected to help in completing the dashboard by providing service and other data regularly. Data sources and dates are listed directly in the dashboard for easy reference. The dashboard is available from MCDMCH upon request for review, and is also updated and distributed quarterly for review at regular FP TWG meetings.

The dashboard includes three kinds of outcome indicators: specific outcome indicators related to plan activities, as listed in the full implementation matrix, overall outcome indicators tracking the plan's objectives, and impact indicators. Together, these allow for the monitoring of the plan's progress, for individual activities, overall progress, and impact on the health system.

- Specific outcome indicators:
  - Demand
    - Contact of non-users with FP providers (% educated about FP)
    - Acceptability of media messages on FP
    - FP2020 myth-dispelling commitment: dialogue with religious and traditional leaders
  - Service delivery and access
    - Services provided by GRZ facilities, including CBDs, by method
    - Services provided by NGOs, by method
    - Of all services provided, those provided to adolescents and youth (15-24 years of age)
    - Source of supply for modern contraceptive methods

- Informed choice (as defined in the DHS, % of users who were informed about side effects, what to do if they experience side effects, and other methods they could use)
- Competence of providers (as part of regular supervisions, % judged to have satisfactorily completed counseling, service delivery, and supervision)
- Size of pool of trainers in FP
- Number of providers trained in LARC

– Procurement and supply chain
- Months of stock at central level, by method
- Stock-outs at central level, by method
- Stock-outs at facility level, by method (average days out of stock)

– Policy and environment
- FP2020 policy barriers commitment: task-shifting to CHAs and CBDs

– Financing
- Budget line
  - Budget line for FP services (both MCDMCH and MOH)
  - Budget line for FP commodities (or RH commodities, until the FP commodity budget line is created)
- FP2020 budgetary commitment: doubling of FP commodity budget line

– Supervision, monitoring and coordination
- Percentage of facilities reporting
  - HMIS
  - Stock reports and orders to MSL
  - Supervisory reports

■ Overall indicators (for comparison against objectives):

– MCPR (both married women only and all women of reproductive age)
- From DHS
- From any other government or partner studies
- Implied from facility-level data, from attendance, and methods distributed and removed

– Unmet need

– Teenage pregnancy

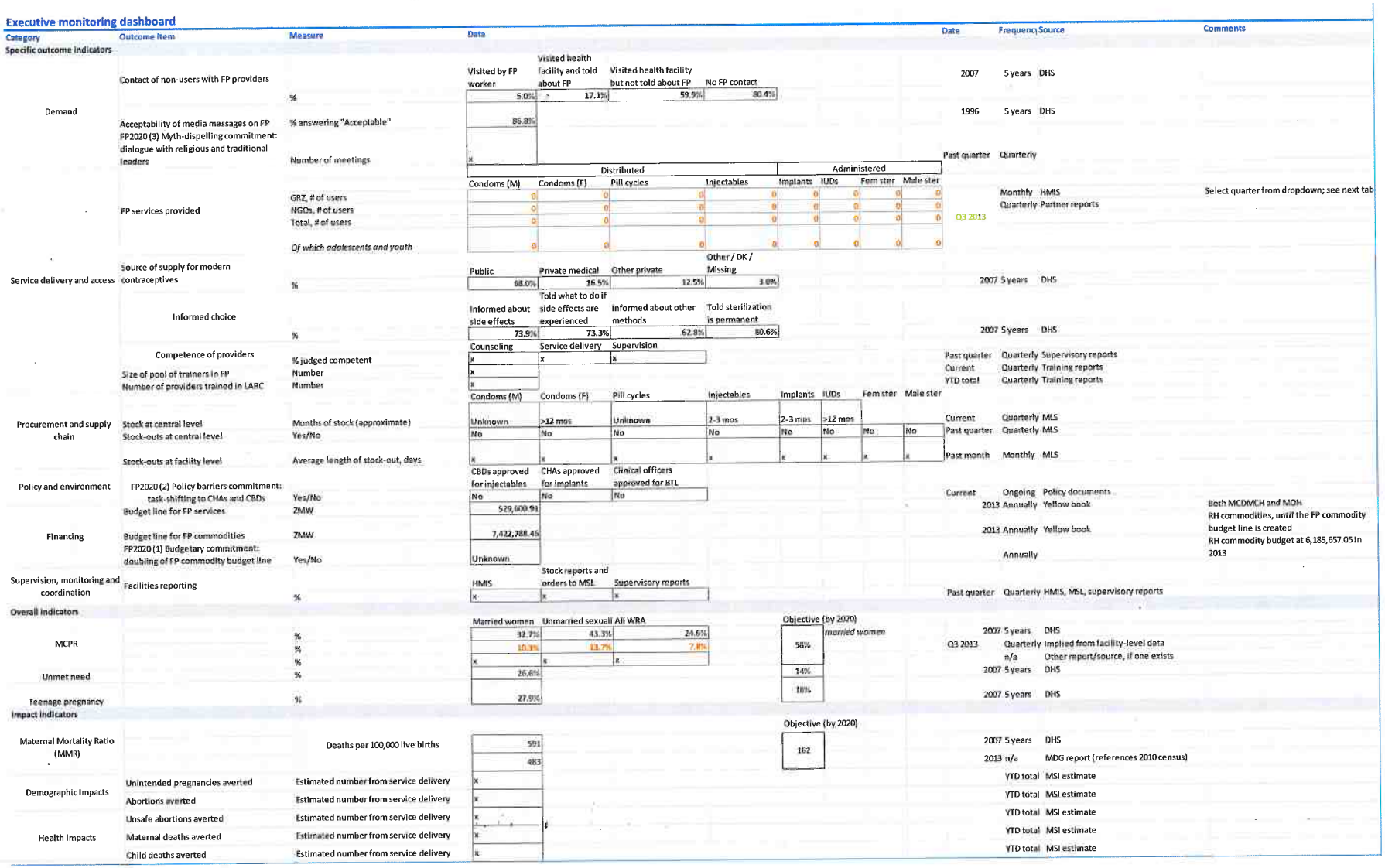
■ Impact indicators

– Unintended pregnancies and abortions averted (MSI estimate based on service delivery)

– Maternal mortality ratio

– Unsafe abortion, maternal deaths and child deaths averted (MSI estimate based on service delivery)

Chart 5: Sample view of dashboard, as of August 2013



Executive monitoring dashboard

Category	Outcome item	Measure	Data	Date	Frequency	Source	Comments
Specific outcome indicators							
Demand	Contact of non-users with FP providers	%	Visited by FP worker: 5.0% · Visited health facility and told about FP: 17.1% · Visited health facility but not told about FP: 59.9% · No FP contact: 80.4%	2007	5 years	DHS	
	Acceptability of media messages on FP	% answering "Acceptable"	86.8%	1996	5 years	DHS	
	FP2020 (3) Myth-dispelling commitment: dialogue with religious and traditional leaders	Number of meetings	x	Past quarter	Quarterly		
	FP services provided	GRZ, # of users / NGOs, # of users / Total, # of users / *Of which adolescents and youth*	Distributed: Condoms (M) · Condoms (F) · Pill cycles · Injectables; Administered: Implants · IUDs · Fem ster · Male ster — all 0	Q3 2013	Monthly / Quarterly	HMIS / Partner reports	Select quarter from dropdown; see next tab
Service delivery and access	Source of supply for modern contraceptives	%	Public: 68.0% · Private medical: 16.5% · Other private: 12.5% · Other / DK / Missing: 3.0%	2007	5 years	DHS	
	Informed choice	%	Informed about side effects: 73.9% · Told what to do if side effects are experienced: 73.3% · Informed about other methods: 62.8% · Told sterilization is permanent: 80.6%	2007	5 years	DHS	
	Competence of providers	% judged competent	Counseling: x · Service delivery: x · Supervision: x	Past quarter	Quarterly	Supervisory reports	
	Size of pool of trainers in FP	Number	x	Current	Quarterly	Training reports	
	Number of providers trained in LARC	Number	x	YTD total	Quarterly	Training reports	
Procurement and supply chain	Stock at central level	Months of stock (approximate)	Condoms (M): Unknown · Condoms (F): >12 mos · Pill cycles: Unknown · Injectables: 2-3 mos · Implants: 2-3 mos · IUDs: >12 mos · Fem ster: No · Male ster: No	Current	Quarterly	MLS	
	Stock-outs at central level	Yes/No	No / No / No / No / No / No / No / No	Past quarter	Quarterly	MLS	
	Stock-outs at facility level	Average length of stock-out, days	x / x / x / x / x / x / x / x	Past month	Monthly	MLS	
Policy and environment	FP2020 (2) Policy barriers commitment: task-shifting to CHAs and CBDs	Yes/No	CBDs approved for injectables: No · CHAs approved for implants: No · Clinical officers approved for BTL: No	Current	Ongoing	Policy documents	
	Budget line for FP services	ZMW	529,600.91	2013	Annually	Yellow book	Both MCDMCH and MOH RH commodities, until the FP commodity budget line is created
Financing	Budget line for FP commodities	ZMW	7,422,788.46	2013	Annually	Yellow book	RH commodity budget at 6,185,657.05 in 2013
	FP2020 (1) Budgetary commitment: doubling of FP commodity budget line	Yes/No	Unknown		Annually		
Supervision, monitoring and coordination	Facilities reporting	%	HMIS: x · Stock reports and orders to MSL: x · Supervisory reports: x	Past quarter	Quarterly	HMIS, MSL, supervisory reports	
Overall indicators							
MCPR		%	Married women: 32.7% · Unmarried sexuall: 43.3% · All WRA: 24.6%	Objective (by 2020) married women: 58%	2007	5 years	DHS
		%	10.3% · 13.7% · 7.8%		Q3 2013	Quarterly	Implied from facility-level data
		%	x · x · x			n/a	Other report/source, if one exists
Unmet need		%	26.6%	14%	2007	5 years	DHS
Teenage pregnancy		%	27.9%	18%	2007	5 years	DHS
Impact indicators							
Maternal Mortality Ratio (MMR)		Deaths per 100,000 live births	591 / 483	Objective (by 2020): 162	2007	5 years	DHS
					2013	n/a	MDG report (references 2010 census)
Demographic Impacts	Unintended pregnancies averted	Estimated number from service delivery	x			YTD total	MSI estimate
	Abortions averted	Estimated number from service delivery	x			YTD total	MSI estimate
Health impacts	Unsafe abortions averted	Estimated number from service delivery	x			YTD total	MSI estimate
	Maternal deaths averted	Estimated number from service delivery	x			YTD total	MSI estimate
	Child deaths averted	Estimated number from service delivery	x			YTD total	MSI estimate

Simplified roadmap

The simplified roadmap is a supervision tool to ensure efficient implementation of the plan. It gives a breakdown of all activities occurring by year and category. Quarterly checks correspond to the quarterly review meetings that are held at the district and provincial levels by the FP coordinators, where progress on each activity can be tracked. The tool can also be used semi-annually at the national review meetings.

Note that these are the same activities as in the implementation framework, just presented differently for easy reference. Each quarter lists the sub-activity elements that should take place, the expected outcome, and who is responsible.

2013

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
Q3 2013	D1.4	Integrate FP into existing health campaigns	▪ Number of community mobilization events (health campaigns, 6)	MCDMCH Principal FP Officer and MCDMCH FP specialist
	SDA2.1	Develop a national training plan to execute high-impact, decentralized, cost-effective training on FP in coordination with the National Health Training Plan under review by MOH	▪ Number of documents produced (Finalized National FP training plan, 1)	MCDMCH Chief FP Officer, with support from MOH
	SDA2.2	Collect and review all existing in-service training manuals	▪ Number of documents produced (FP training manuals, 5)	MOH trainer, with support from MCDMCH Chief FP Officer
	SDA7.3	Conduct demonstration of Injectable use by 20 CBDs in each of 3 districts	▪ Number of trainees (CBDs, injectables 60)	MCDMCH
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	▪ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	SDA11.1	Engage consultant to develop basic package for integration	▪ Number of documents produced (clinical guidelines for FP integration) ▪ Number of meetings (FP TWG sub-committee on FP Service Integration)	MCDMCH
	PSC1.1	Hold quarterly forecast review meetings	▪ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinator
	PE3.1	Identify barriers adolescent access to FP in current FP Guidelines	▪ Inclusion in FP TWG agenda (under-16 access to FP services) ▪ Inclusion in FP TWG agenda (task-shifting) Number of meetings (FP guidelines review)	FP TWG
		During revision of FP guidelines, ensure wording around under-16 access to contraceptives is unambiguous	▪ Inclusion in FP TWG agenda (under-16 access to FP services) ▪ Inclusion in FP TWG agenda (task-shifting) ▪ Number of meetings (FP guidelines review)	MCDMCH FP specialist

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
	PE3.2	Change the MCDMCH policies to allow CBDs to give injectables, and CHAs to provide implants	■ Inclusion in FP TWG agenda (under-16 access to FP services) ■ Inclusion in FP TWG agenda (task-shifting) ■ Number of meetings (FP guidelines review)	FP TWG
	SMC1.1	Put in place a central FP lead at the MCDMCH	■ Number of resources hired (RH Specialist, 1)	MCDMCH Director MCH
		Hire additional resources needed at the central level for the plan's successful implementation, specifically for program management, outreach, and logistics	■ Number of resources hired (Chief FP Officer, 1; Principal FP Officer, 1; RH Logistics Coordinator, 1)	MCDMCH Deputy Director MCH
		Provide the FP division with necessary ongoing working equipment	■ Numbers of equipment procured (laptops, 4; printers, 3; desks, 2; chairs, 4; bookshelves, 4; vehicle, 1)	MCDMCH FP specialist
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC1.3	Distribute copies of the 8 year FP scale-up plan and executive summary brochure to officials at national, provincial and district levels	■ Number of documents disseminated (FP plan; executive summary brochure)	MCDMCH
	SMC2.1	Define indicators to be tracked as part of plan implementation in the executive dashboard	■ Number of documents produced (list of HMIS indicators to track, 1)	TST; 2017 review by MCDMCH FP specialist
	SMC2.2	Review current supervision tools	■ Number of documents produced (supervision tools, 1) ■ Percentage of facilities using the new supervisory tools	MCDMCH FP specialist
	SMC2.3	Development of Executive Dashboard	■ Number of documents produced (executive monitoring dashboard, 1)	TST
		Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise annually from central level to provinces	■ Number of supervisory visits conducted (to provinces, annually)	MCDMCH Chief FP Officer

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		Supervise semi-annually from provincial level to districts	■ Number of supervisory visits conducted (to districts, semi-annually)	Provincial-level FP coordinators
		Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre In Charges
	SMC4.3	Hold semi-annual review meetings to revise progress on FP plan at central level	■ Number of meetings (national FP review, 2 a year)	MCDMCH MCH Deputy Director with support from full FP team
		Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
Q4 2013	D1.1	Hire a consultant to spend 30 days developing a communi-cations strategy, including effective messaging and channels to use to promote FP	■ Number of documents produced (communications strategy, 1)	MCDMCH communications team
	D2.1	Identify and select FP change champions via consultations between MCDMCH, the National FP Technical Working Group, and other stakeholders	■ Number of trainees (national FP change champions, 3-5 a year)	MCDMCH Principal FP Officer
	SDA1.1	Develop and pretest an integrated assessment tool	■ Number of documents produced (Integrated Assessment tool, 1) ■ Research conducted (assessment of facilities, partners coverage map, gap analysis) ■ Number of documents produced (FP coverage map and partner matrix, 1 per district) ■ Number of meetings (FP TWG sub-committee on Partner Coordination)	MCDMCH Chief FP Officer
		Use the assessment tool to conduct facility assessments for all districts to identify FP gaps and partner involvement		
		Update FP partner matrix and coverage map		
		Disseminate the findings from the national situation analysis, partner matrix and coverage map		
	SDA1.2	Update the pre-service national training database to include information about in-service training	■ Number of updates (training database, 1 a year)	District FP coordinator
	SDA7.3	Review results of CBD injectables scale-up demonstration	■ Number of meetings (FP TWG sub-committee on CBD Injectables program)	FP TWG
		Advocate for Policy Change to allow CBDs to distribute injectables	■ Number of documents produced (recommendations on CBD	FP TWG

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			injectables)	
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold annual forecasting and quantification workshops	■ Number of meetings (forecasting and quantification workshop, 1 a year) ■ Number of documents produced (annual forecast and procurement plan, 1 a year) ■ Percentage of procurement plan financed	MOH & MCDMCH RHCS Coordinators
		Create national , cross sector supply plan and procure FP commodities		MOH & MCDMCH RHCS Coordinators
		Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	F1.2	Mapping of development partners interested in supporting FP	■ Number of meetings (advocacy to partners, 1)	MCDMCH Principal FP Officer with support from FP specialist
		Organize a meeting with FP development partners for repositioning of FP, inviting donor commitments	■ Number of meetings (advocacy to partners, 1)	MCDMCH, organized by Principal FP Officer
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC1.3	Train/orient FP coordinators at the provincial and district level	■ Number of trainees (provincial FP focal points, orientation, 1 per province) ■ Number of trainees (district FP focal points, orientation, 1 per district)	Coordinated by MCDMCH FP specialist;
	SMC2.1	Review the existing M&E data collection tools and make recommendations	■ Number of documents produced (M&E collection tools, 1)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.1	Train provincial and district-level FP coordinators in coordination	■ Number of trainees (provincial and district-level	MCDMCH FP Specialist

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		supervision	FP focal points, FP supervision, 1 per province and 1 per district)	
	SMC3.2	Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre In charges
	SMC4.3	Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
2013	SDA3.1	Train FP Trainers in each province	■ Number of trainees (trainers, FP for HCWs, 40 a year)	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA3.2	Train CBD and peer educator trainers in each province	■ Number of trainees (trainers, CBD and peer educators, 40 a year)	Trainers, coordinated by MCDMCH Chief FP Officer with support from MCDMCH Principal FP Officer
	SDA4.1	Train a cadre of HCWs annually in LARC, to ensure sufficient LARC providers at all health centres and hospitals	■ Number of trainees (HCWs, LARCs, 500 a year) ■ Number of mentorship visits conducted (HCWs trained in LARCs, 500 year)	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA4.2	Conduct mentorship visits in FP for HCWs annually	■ Number of mentorship visits conducted	Trainers, coordinated by MCDMCH Chief FP Officer
	PSC4.1	Procure distribution trucks, for the regional hubs	■ Number of vehicles procured (trucks, 6; 4x4s, 12)	MSL
		Orient provincial hub managers, district logistics officers and health centre leads in the new MSL system	■ Number of trainees (pharmacists and HCWs, new logistics system)	MSL
	PE2.2	Coordinate national prominent FP advocates through bi-annual meetings to share best practices in advocacy and lessons learnt from FP advocacy	■ Number of meetings (FP advocate best-practices, 2 a year) ■ Number of FP advocacy events attended by FP advocates	MCDMCH RH Specialist
Ongoing	D3.2	Brief organizations through in-person meetings and connect to partners	■ Number of initiatives (incorporating FP into youth development activities, 2 a year)	MCDMCH
	SDA2.1	Coordinate training plan	■ Number of documents	MCDMCH Chief FP

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			produced (Finalized National FP training plan, 1)	Officer, and FP TWG sub-committee on In-Service Training
	PSC2.1	Conduct post market surveillance on contraceptives	■ Percentage of contraceptive commodity shipments quality tested	MSL
	PSC4.2	Ensure supply chain system continues to provide accurate and timely re-stocking of CBDs	■ Percentage of CBDs being restocked monthly or more frequently	MCDMCH RH Logistics Coordinator
		Ensure system to provide FP commodities and consumables to dedicated FP provider outreach teams	■ Outreach teams to order and receive from MSL supplies which are used during outreach ■ HCs to continue to order and receive FP commodities and consumables for routine FP services at HCs	MSL, coordinated by MCDMCH RH Logistics Coordinator
	PSC4.3	Utilize the RH Logistics Coordinator to ensure all districts and facilities are ordering commodities, and to address any pressing concerns	■ Percentage of districts reporting and ordering FP commodities (1 a month, all districts) ■ Percentage of health facilities reporting and ordering FP commodities (1 a month, 26 districts)	MCDMCH RH Logistics Coordinator
	PSC3.1	Train logistics trainers	■ Number of trainees (trainers, logistics training)	Coordinated by MCDMCH RH Logistics Coordinator
		Train HCWs in logistics management, including tracking data, calculating monthly consumption and ordering stock	■ Number of trainees (HCWs, logistics training)	Coordinated by MCDMCH RH Logistics Coordinator

2014

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
Q1 2014	D1.2	Prepare, produce, and broadcast radio spots, radio serial drama programs and TV programs on FP	■ Number of communications produced (radio spots, 4 a year; radio dramas, 36 a year; TV episodes, 4 a year) ■ Number of communications disseminated (radio spots, 3650 a year; radio dramas, 720 a year; TV episodes, 8 a year)	MCDMCH communications team
		Orient, encourage, and incentivize media groups to support a multimedia FP campaign to increase media awareness, analytical and reporting capacity for FP	■ Number of trainees (media personnel, FP reporting, 20 a year) ■ *Number of media hits on FP (articles in print and online, TV broadcasts, radio broadcasts)* ■ Number of meetings (press conferences on FP issues, 2 a year) ■ Number of awards (to media journalists, 3 a year)	MCDMCH Principal FP Officer
	D2.1	Recruit, train equip , and deploy national FP change champions	■ Number of trainees (national FP change champions, 3-5 a year)	MCDMCH RH specialist and MCDMCH Principal FP Officer
	D2.2	Identify, select and recruit community FP change champions	■ Number of trainees (community FP promoters, 10 a year per district)	Provincial- and district-level FP coordinators
		Train and deploy recruited FP promoters at the district level	■ Number of community FP promoters trained	Provincial-level FP coordinators in coordination with MCDMCH Principal FP Officer
	D3.1	Work with existing AIDS clubs in selected secondary schools and colleges to introduce AYSRH components, including FP, under the school health program	■ Number of active outreach groups (FP in AIDS clubs, 10-20 a year)	MCDMCH
	SDA2.1	Review and finalize plan with stakeholders	Number of documents produced (Finalized National FP training plan, 1)	FP TWG
		Disseminate training plan		MCDMCH Chief FP Officer
	SDA2.2	Conduct consensus building meeting with key stakeholders to choose one national FP training manual for each type of training	■ Number of meetings (stakeholder consensus on new training manuals,1)	MOH with support from MCDMCH Chief FP Officer
	SDA3.4	Ensure province has the appropriate equipment for FP trainings, especially LARCs	■ Number of equipment distributed (gynaecological simulator, 25; plastic uterus, 25; plastic arm, 25)	MOH RHCS Coordinator
	SDA5.1	Review and strengthen the FP component in pre-service medical school, midwifery and general	■ Number of meetings (technical review of pre-service training, 1)	MOH with support from MCDMCH Chief FP Officer

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		nursing curricula	■ Number of documents produced (revised pre-service curriculum)	
	SDA5.2	Advocate with professional health registration bodies to institute a LARC-related registration requirement	■ Number of new and/or improved registration requirements for health professionals	MCDMCH Chief FP Officer
	SDA7.1	Conduct central review of CBD training curriculum, and get government and partners to agree to standardized CBD compensation	■ Number of meetings (FP TWG sub-committee on CBD Training and Compensation) ■ Number of documents produced (CBD training curriculum; CBD compensation model)	FP TWG
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA8.2	Conduct site assessments of Mini-clinics	■ Number of meetings (FP TWG sub-committee on Mini-clinics)	FP TWG
	SDA10.1	Procure and distribute FP equipment	■ Numbers of equipment procured (FP equipment)	MOH coordinated by MCDMCH RH specialist
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	SDA11.2	Workshop with key stakeholders to agree on the basic package for integration of FP into other health services, in particular HIV services	■ Number of documents produced (clinical guidelines for FP integration) ■ Number of meetings (FP TWG sub-committee on FP Service Integration)	FP TWG
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	PE1.1	Engage consultant to review relevant government policy documents for sections addressing FP	■ Number of documents produced (review of national policy documents)	MCDMCH guidance,
	PE2.1	Identify and recruit prominent FP advocates via consultations between MCDMCH, the National FP Technical Working Group, and other stakeholders	■ Number of trainees (FP advocates, 3-5 a year) ■ Inclusion in FP TWG agenda (FP advocates)	MCDMCH with FP TWG support
	PE3.1	Ensure promotion of the new guidelines	■ Inclusion in FP TWG agenda (under-16 access to FP services) ■ Inclusion in FP TWG agenda (task-shifting) ■ Number of meetings (FP guidelines review)	MCDMCH FP specialist
	F1.2	Develop and implement FP resource allocation advocacy strategy targeting development	■ Number of documents produced (advocacy strategy)	FP TWG

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		partners		
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.1	Standardize information needed from partners to track overall FP progress	■ Number of documents produced (partner update template, 1)	MCDMCH FP specialist
	SMC2.2	Disseminate revised supervision tools to the provincial and district levels	■ Number of documents produced (supervision tools, 1) ■ Percentage of facilities using the new supervisory tools	MCDMCH Chief FP officer with support from MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise semi-annually from provincial level to districts	■ Number of supervisory visits conducted (to districts, semi-annually)	Provincial-level FP coordinators
		Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre In Charges
	SMC4.3	Hold semi-annual review meetings to revise progress on FP plan at central level	■ Number of meetings (national FP review, 2 a year)	MCDMCH MCH Deputy Director with support from full FP team
		Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to	■ Number of meetings	District-level FP

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		revise progress on FP plan at district level	(district FP review, 4 a year per district)	coordinators
Q2 2014	D1.3	Produce and distribute print materials (posters, IEC, BCC materials) to all clinics, public places and training centers	■ Number of communications produced (posters, flyers, brochures, fact sheets, in 6 languages) ■ Number of communications disseminated	MCDMCH communications team
	D1.4	Celebrate World Population Day	■ Number of community mobilization events (health campaigns, 6)	MCDMCH Principal FP Officer
	D2.2	Orient FP coordinators about the FP promoters initiative	■ Number of meetings (FP coordinator orientation on FP promoters initiative, 1)	MCDMCH Principal FP Officer
	SDA2.2	Conduct one day orientation and launch meeting for FP TWG members	■ Inclusion in FP TWG agenda (orientation to new training manuals)	FP TWG
	SDA3.3	Train 6 dedicated FP in-service trainers to pilot dedicated trainer model	■ Number of trainees (dedicated trainers, FP for HCW, 12)	Coordinated by MCDMCH,
	SDA5.1	Train clinical instructors and nursing tutors (from each of the nursing and medical schools) per year in LARC practical skills	■ Number of trainees (tutors and clinical instructors, trainer of LARC methods, 40-80 a year)	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA7.2	Orient provincial and district officials to the CBD program	■ Number of meetings (CBD role, 1 per province)	MCDMCH Principal FP Officer with support from provincial-level FP coordinators
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA8.2	Develop infrastructure for all 5 pilot mini clinic facilities	■ Number of facilities established (mini-clinics, 5)	MCDMCH Principal FP Officer
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	SDA11.2	Orient officials and trainers to the new integration package	■ Number of documents produced (clinical guidelines for FP integration) ■ Number of meetings (FP TWG sub-committee on FP Service Integration)	MCDMCH Chief FP Officer
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	PSC1.2	Review feasibility of prepackaged FP consumables with commodeties, either as part of the existing emergency medicines pack or separately	■ Number of meetings (discussion on prepacked commodities, 1)	MCDMCH RH Logistics Coordinator
	PSC5.1	Conduct mapping of contraceptive commodities at every level	■ Number of documents produced (mapping of commodity flow)	MCDMCH RH Logistics Coordinator

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			■ Number of updates (mapping, 4 times a year)	
	PSC 6.1	Create clear and quick request, approval, and dispensing process for partners to receive FP commodities from MSL	■ Number of days of delay in commodity order	MCDMCH RH Logistics Coordinator and MSL
	PE1.1	Conduct a consultation meeting to reach consensus on inclusion of FP in major national policy documents, strategies and plans	■ Number of meetings (FP TWG sub-committee on FP policy) ■ Number of documents produced (revised national policies)	FP TWG
	F1.1	Advocate with key stakeholders (MOF, MOH, and parliamentarians)	■ Number of documents produced (policy brief on FP budgeting) ■ Number of meetings (advocacy to parliamentarians, 1 a year) ■ Amount of FP budget lines (MCDMCH, for FP management/programming ; MOH, for FP commodities; provincial level; district level)	MCDMCH RH specialist, with support from policy advocacy group
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC1.3	Approve provincial and district-level objectives in the plan	■ Number of meetings (provincial FP coordinator objective review, 1 a year)	Provincial- and district-level FP coordinators
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre In Charges
	SMC4.2	Update objectives or revise activities as needed based on DHS data	■ Number of documents produced (updated objectives, 1; updated implementation plan if needed, 1)	FP TWG
	SMC4.3	Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
Q3 2014	D1.4	Integrate FP into existing health campaigns	■ Number of community mobilization events (health campaigns, 6)	MCDMCH Principal FP Officer and MCDMCH FP specialist
	SDA4.3	Train 1 midwife per district to offer only FP services, primarily long-acting methods like IUDs and implants	■ Number of new staff hired (midwives, 100) ■ Number of trainees (midwives, dedicated FP, 100 a year) ■ Number of mentorship visits conducted (FP dedicated midwives, 100 year)	Trainers, coordinated by MCDMCH Chief FP Officer with support from MCDMCH Principal FP Officer to recruit the midwives
	SDA5.1	Train clinical instructors and nursing tutors (from each of the nursing and medical schools) per year in LARC practical skills	■ Number of trainees (tutors and clinical instructors, trainer of LARC methods, 40-80 a year)	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA8.2	Equip the mini clinic facilities with basic equipment for FP Ensure necessary staff for mini clinics	■ Number of facilities established (mini-clinics, 5)	MCDMCH Principal FP Officer
	SDA8.3	Hold meetings with private stakeholders to identify opportunities to expand access	■ Number of meetings (advocacy with donors, 15) ■ Number of PPPs established (FP) ■ Amount of financial contributions (FP programs, ZMW)	MCDMCH Deputy Director, with support from RH specialist
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	SDA11.2	Work with hospitals which have a post-abortion care ward to integrate provision of FP (including all methods) as part of post-abortion care for all women	■ Number of documents produced (clinical guidelines for FP integration) ■ Number of meetings (FP	MCDMCH RH Specialist

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			TWG sub-committee on FP Service Integration)	
	SDA12.1	Equip Service Points	■ Number of facilities with youth friendly service points established	MCDMCH Principal FP Officer
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.1	Train health facility level supervisors in FP supervision	■ Number of trainees (heatl facility supervisors, FP supervision, 300 a year)	MCDMCH
	SMC3.2	Supervise annually from central level to provinces	■ Number of supervisory visits conducted (to provinces, annually)	MCDMCH Chief FP Officer
		Supervise semi-annually from provincial level to districts	■ Number of supervisory visits conducted (to districts, semi-annually)	Provincial-level FP coordinators
		Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre In Charges
	SMC4.3	Hold semi-annual review meetings to revise progress on FP plan at central level	■ Number of meetings (national FP review, 2 a year)	MCDMCH MCH Deputy Director with support from full FP

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
				team
		Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
Q4 2014	D1.2	Establish and facilitate radio listening groups building on established SMAGs	■ Number of documents produced (discussion guidelines, 1) ■ Number of active outreach groups (radio listening groups, 2400)	MCDMCH
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
		Ensure mini clinics are incorporated in supply chain system and reporting/ ordering directly from MSL	■ Number of facilities established (mini-clinics, 5)	MCDMCH RH Logistics Coordinator
	SDA8.3	Advocate with corporations to fund FP at the national level through corporate social responsibility initiatives	■ Number of meetings (advocacy with donors, 15) ■ Number of PPPs established (FP) ■ Amount of financial contributions (FP programs, ZMW)	FP TWG
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold annual forecasting and quantification workshops	■ Number of meetings (forecasting and quantification workshop, 1 a year) ■ Number of documents produced (annual forecast and procurement plan, 1 a year) ■ Percentage of procurement plan financed	MOH & MCDMCH RHCS Coordinators
		Create national , cross sector supply plan and procure FP commodities		MOH & MCDMCH RHCS Coordinators
		Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month)	MCDMCH FP specialist

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre In Charges
	SMC4.3	Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
2014	D3.1	Train peer educators to manage AYSRH clubs	■ Number of active outreach groups (AYSRH clubs in youth centres, 50 a year) ■ Number of trainees (teachers, peer educator trainers and mentors, 60 a year) ■ Number of trainees (peer educators and youth CBDs, 100 a year)	MCDMCH
	SDA2.3	Conduct pilot to assess the feasibility and safety of clinical officers conducting tubal ligations	■ Inclusion in FP TWG agenda (Clinical officer BTL pilot)	MCDMCH
	SDA3.1	Train FP Trainers in each province	■ Number of trainees (trainers, FP for HCWs, 40 a year)	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA3.2	Train CBD and peer educator trainers in each province	■ Number of trainees (trainers, CBD and peer educators, 40 a year)	Trainers, coordinated by MCDMCH Chief FP Officer with support from MCDMCH Principal FP Officer
	SDA4.1	Train a cadre of HCWs annually in LARC, to ensure sufficient LARC providers at all health	■ Number of trainees (HCWs, LARCs, 500 a year) ■ Number of mentorship	Trainers, coordinated by MCDMCH Chief FP Officer

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		centres and hospitals	visits conducted (HCWs trained in LARCs, 500 year)	
	SDA4.2	Conduct mentorship visits in FP for HCWs annually	■ Number of mentorship visits conducted	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA7.2	Train 300 Community Based Distributors (CBDs) a year in FP methods on average , to have on average 4 CBDs per health care centre	■ Number of trainees (CBDs, FP methods, 300 a year)	Trainers, coordinated by MCDMCH Principal FP Officer
		Provide follow-up and supervision of CBDs	■ Number of mentorship visits conducted (CBDs, 300 a year)Number of providers offering FP (active CBDs)	Trainers, coordinated by MCDMCH Principal FP Officer with support from district-level FP coordinators
	SDA7.3	Scale-up CBD injectables to the whole country, once pilot and report approved	■ Number of trainees (existing CBDs, injectables ~1800)	MCDMCH coordinating all partners with CBDs
	PSC4.1	Procure distribution trucks, for the regional hubs	■ Number of vehicles procured (trucks, 6; 4x4s, 12)	MSL
		Orient provincial hub managers, district logistics officers and health centre leads in the new MSL system	■ Number of trainees (pharmacists and HCWs, new logistics system)	MSL
	PSC4.2	Support infrastructure for the distribution of contraceptives at sub-district level for facilities not yet reached by MSL decentralization [Only percentage related to FP commodities considered part of overall FP budget, as still critical to plan implementation]	■ Number of vehicles procured (4x4s)	MSL
	PE2.2	Coordinate national prominent FP advocates through bi-annual meetings to share best practices in advocacy and lessons learnt from FP advocacy	■ Number of meetings (FP advocate best-practices, 2 a year) ■ Number of FP advocacy events attended by FP advocates	MCDMCH RH Specialist
Ongoing	D1.2	Establish and facilitate radio listening groups building on established SMAGs	■ Number of documents produced (discussion guidelines, 1) ■ Number of active outreach groups (radio listening groups, 2400)	MCDMCH
	D3.1	Support the roll-out of the new adolescent SRH curriculum in schools	■ SRH public school education curriculum corresponds to Measure Evaluation PRH "best practices" ■ Number of meetings (FP TWG sub-committee on Adolescent SRH Curriculum)	FP TWG
	D3.2	Brief organizations through in-	■ Number of initiatives	MCDMCH

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		person meetings and connect to partners	(incorporating FP into youth development activities, 2 a year)	
	SDA2.1	Coordinate training plan	■ Number of documents produced (Finalized National FP training plan, 1)	MCDMCH Chief FP Officer, and FP TWG sub-committee on In-Service Training
	SDA3.3	Train 6 dedicated FP in-service trainers to pilot dedicated trainer model	■ Number of trainees (dedicated trainers, FP for HCW, 12)	Coordinated by MCDMCH,
	SDA6.1	Trained dedicated FP midwives (*SDA4.3*) provide the full package of non-permanent FP methods at health facilities	■ Number of providers offering FP (dedicated midwives, 1 per district)	Dedicated midwives, coordinated by the district-level FP coordinators
		Dedicated FP providers' outreach locations and schedule changes over time as HCW shortage is alleviated in Zambia	■ Number of mentorship visits conducted (dedicated midwives)	Dedicated midwives, coordinated by the district-level FP coordinators
	PSC2.1	Conduct post market surveillance on contraceptives	■ Percentage of contraceptive commodity shipments quality tested	MSL
	PSC4.2	Ensure supply chain system continues to provide accurate and timely re-stocking of CBDs	■ Percentage of CBDs being restocked monthly or more frequently	MCDMCH RH Logistics Coordinator
		Ensure system to provide FP commodities and consumables to dedicated FP provider outreach teams	■ Outreach teams to order and receive from MSL supplies which are used during outreach ■ HCs to continue to order and receive FP commodities and consumables for routine FP services at HCs	MSL, coordinated by MCDMCH RH Logistics Coordinator
	PSC4.3	Utilize the RH Logistics Coordinator to ensure all districts and facilities are ordering commodities, and to address any pressing concerns	■ Percentage of districts reporting and ordering FP commodities (1 a month, all districts) ■ Percentage of health facilities reporting and ordering FP commodities (1 a month, 26 districts)	MCDMCH RH Logistics Coordinator
	PSC5.1	Update mapping and troubleshoot with facilities whose consumption does not match expectations	■ Number of documents produced (mapping of commodity flow) ■ Number of updates (mapping, 4 times a year)	MCDMCH RH Logistics Coordinator
	PSC 6.1	Ensure partners received the ordered stocks	■ Number of days of delay in commodity order	MCDMCH RH Logistics Coordinator
	PE2.2	Provide technical support to prominent FP advocates	■ Number of meetings (FP advocate best-practices, 2 a year) ■ Number of FP advocacy events attended by FP advocates	MCDMCH FP team
	PE2.3	Prominent FP advocates to	■ Number of FP advocacy	FP advocates

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		attend advocacy meetings with government, donors and partners, internationally, nationally, provincially and at the local level	events attended by FP advocates	
	PSC3.1	Train logistics trainers	■ Number of trainees (trainers, logistics training)	MCDMCH RH Logistics Coordinator, coordinating partners
		Train HCWs in logistics management, including tracking data, calculating monthly consumption and ordering stock	■ Number of trainees (HCWs, logistics training)	MCDMCH RH Logistics Coordinator, coordinating partners

2015

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
Q1 2015	D1.2	Prepare, produce, and broadcast radio spots, radio serial drama programs and TV programs on FP	■ Number of communications produced (radio spots, 4 a year; radio dramas, 36 a year; TV episodes, 4 a year) ■ Number of communications disseminated (radio spots, 3650 a year; radio dramas, 720 a year; TV episodes, 8 a year)	MCDMCH communications team
		Orient, encourage, and incentivize media groups to support a multimedia FP campaign to increase media awareness, analytical and reporting capacity for FP	■ Number of trainees (media personnel, FP reporting, 20 a year) ■ *Number of media hits on FP (articles in print and online, TV broadcasts, radio broadcasts)* ■ Number of meetings (press conferences on FP issues, 2 a year) ■ Number of awards (to media journalists, 3 a year)	MCDMCH Principal FP Officer
	D2.2	Identify, select and recruit community FP change champions	■ Number of trainees (community FP promoters, 10 a year per district)	Provincial- and district-level FP coordinators
		Train and deploy recruited FP promoters at the district level	■ Number of community FP promoters trained ■	Provincial-level FP coordinators in coordination with MCDMCH Principal FP Officer
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA 9.1	Explore feasibility and make recommendation	■ Number of meetings (FP TWG sub-committee on CHA Implants) ■ Number of documents	FP TWG

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			produced (recommendations on CHA implants)	
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.1	Train health facility level supervisors in FP supervision	■ Number of trainees (heatl facility supervisors, FP supervision, 300 a year)	
	SMC3.2	Supervise semi-annually from provincial level to districts	■ Number of supervisory visits conducted (to districts, semi-annually)	Provincial-level FP coordinators
		Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre In Charges
	SMC4.3	Hold semi-annual review meetings to revise progress on FP plan at central level	■ Number of meetings (national FP review, 2 a year)	MCDMCH MCH Deputy Director with support from full FP team

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
Q2 2015	D1.4	Celebrate World Population Day	■ Number of community mobilization events (health campaigns, 6)	MCDMCH Principal FP Officer
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least	Health centre In Charges

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			quarterly)	
	SMC4.3	Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
Q3 2015	D1.4	Integrate FP into existing health campaigns	■ Number of community mobilization events (health campaigns, 6)	MCDMCH Principal FP Officer and MCDMCH FP specialist
	SDA4.3	Train 1 midwife per district to offer only FP services, primarily long-acting methods like IUDs and implants	■ Number of new staff hired (midwives, 100) ■ Number of trainees (midwives, dedicated FP, 100 a year) ■ Number of mentorship visits conducted (FP dedicated midwives, 100 year)	Trainers, coordinated by MCDMCH Chief FP Officer with support from MCDMCH Principal FP Officer to recruit the midwives
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA 9.1	Adjust policy to reflect recommendations of TWG sub-committee on feasibility of CHA Implants	■ Number of meetings (FP TWG sub-committee on CHA Implants) ■ Number of documents produced (recommendations on CHA implants)	FP TWG
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors,	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		particularly for integration with HIV activities		
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise annually from central level to provinces	■ Number of supervisory visits conducted (to provinces, annually)	MCDMCH Chief FP Officer
		Supervise semi-annually from provincial level to districts	■ Number of supervisory visits conducted (to districts, semi-annually)	Provincial-level FP coordinators
		Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre In Charges
	SMC4.3	Hold semi-annual review meetings to revise progress on FP plan at central level	■ Number of meetings (national FP review, 2 a year)	MCDMCH MCH Deputy Director with support from full FP team
		Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
Q4 2015	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA 9.1	Revise CHA training curriculum	■ Number of documents produced (revised CHA curriculum)	MCDMCH
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold annual forecasting and quantification workshops	■ Number of meetings (forecasting and quantification workshop, 1 a year) ■ Number of documents produced (annual forecast and procurement plan, 1 a year)	MOH & MCDMCH RHCS Coordinators

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			■ Percentage of procurement plan financed	
		Create national , cross sector supply plan and procure FP commodities		MOH & MCDMCH RHCS Coordinators
		Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre In Charges
	SMC4.3	Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
2015	D3.1	Train peer educators to manage AYSRH clubs	■ Number of active outreach groups (AYSRH clubs in youth centres, 50 a year) ■ Number of trainees (teachers, peer educator	MCDMCH

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			trainers and mentors, 60 a year) ■ Number of trainees (peer educators and youth CBDs, 100 a year)	
	SDA2.3	Conduct pilot to assess the feasibility and safety of clinical officers conducting tubal ligations	■ Inclusion in FP TWG agenda (Clinical officer BTL pilot)	MCDMCH
	SDA3.1	Train FP Trainers in each province	■ Number of trainees (trainers, FP for HCWs, 40 a year)	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA3.2	Train CBD and peer educator trainers in each province	■ Number of trainees (trainers, CBD and peer educators, 40 a year)	Trainers, coordinated by MCDMCH Chief FP Officer with support from MCDMCH Principal FP Officer
	SDA4.1	Train a cadre of HCWs annually in LARC, to ensure sufficient LARC providers at all health centres and hospitals	■ Number of trainees (HCWs, LARCs, 500 a year) ■ Number of mentorship visits conducted (HCWs trained in LARCs, 500 year)	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA4.2	Conduct mentorship visits in FP for HCWs annually	■ Number of mentorship visits conducted	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA7.2	Train 300 Community Based Distributors (CBDs) a year in FP methods on average , to have on average 4 CBDs per health care centre	■ Number of trainees (CBDs, FP methods, 300 a year)	Trainers, coordinated by MCDMCH Principal FP Officer
		Provide follow-up and supervision of CBDs	■ Number of mentorship visits conducted (CBDs, 300 a year)Number of providers offering FP (active CBDs)	Trainers, coordinated by MCDMCH - Principal FP Officer with support from district-level FP coordinators
	SDA7.3	Scale-up CBD injectables to the whole country, once pilot and report approved	■ Number of trainees (existing CBDs, injectables ~1800)	MCDMCH coordinating all partners with CBDs
	PSC4.1	Procure distribution trucks, for the regional hubs	■ Number of vehicles procured (trucks, 6; 4x4s, 12)	MSL
		Orient provincial hub managers, district logistics officers and health centre leads in the new MSL system	■ Number of trainees (pharmacists and HCWs, new logistics system)	MSL
	PE2.2	Coordinate national prominent FP advocates through bi-annual meetings to share best practices in advocacy and lessons learnt from FP advocacy	■ Number of meetings (FP advocate best-practices, 2 a year) ■ Number of FP advocacy events attended by FP advocates	MCDMCH RH Specialist

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
Ongoing	D1.2	Establish and facilitate radio listening groups building on established SMAGs	■ Number of documents produced (discussion guidelines, 1) ■ Number of active outreach groups (radio listening groups, 2400)	MCDMCH
	D3.1	Support the roll-out of the new adolescent SRH curriculum in schools	■ SRH public school education curriculum corresponds to Measure Evaluation PRH "best practices" ■ Number of meetings (FP TWG sub-committee on Adolescent SRH Curriculum)	FP TWG
	D3.2	Brief organizations through in-person meetings and connect to partners	■ Number of initiatives (incorporating FP into youth development activities, 2 a year)	MCDMCH
	SDA2.1	Coordinate training plan	■ Number of documents produced (Finalized National FP training plan, 1)	MCDMCH Chief FP Officer, and FP TWG sub-committee on In-Service Training
	SDA3.3	Train 6 dedicated FP in-service trainers to pilot dedicated trainer model	■ Number of trainees (dedicated trainers, FP for HCW, 12)	Coordinated by MCDMCH
	SDA6.1	Trained dedicated FP midwives (*SDA4.3*) provide the full package of non-permanent FP methods at health facilities	■ Number of providers offering FP (dedicated midwives, 1 per district)	Dedicated midwives, coordinated by the district-level FP coordinators
		Dedicated FP providers' outreach locations and schedule changes over time as HCW shortage is alleviated in Zambia	■ Number of mentorship visits conducted (dedicated midwives)	Dedicated midwives, coordinated by the district-level FP coordinators
	SDA8.3	Advocate with corporations to fund FP at the national level through corporate social responsibility initiatives	■ Number of meetings (advocacy with donors, 15) ■ Number of PPPs established (FP) ■ Amount of financial contributions (FP programs, ZMW)	FP TWG
	PSC2.1	Conduct post market surveillance on contraceptives	■ Percentage of contraceptive commodity shipments quality tested	MSL
	PSC4.2	Ensure supply chain system continues to provide accurate and timely re-stocking of CBDs	■ Percentage of CBDs being restocked monthly or more frequently	MCDMCH RH Logistics Coordinator
		Ensure system to provide FP commodities and consumables to dedicated FP provider outreach teams	■ Outreach teams to order and receive from MSL supplies which are used during outreach ■ HCs to continue to order and receive FP commodities and consumables for routine FP	MSL, coordinated by MCDMCH RH Logistics Coordinator

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			services at HCs	
	PSC4.3	Utilize the RH Logistics Coordinator to ensure all districts and facilities are ordering commodities, and to address any pressing concerns	■ Percentage of districts reporting and ordering FP commodities (1 a month, all districts) ■ Percentage of health facilities reporting and ordering FP commodities (1 a month, 26 districts)	MCDMCH RH Logistics Coordinator
	PSC5.1	Update mapping and troubleshoot with facilities whose consumption does not match expectations	■ Number of documents produced (mapping of commodity flow) ■ Number of updates (mapping, 4 times a year)	MCDMCH RH Logistics Coordinator
	PSC 6.1	Ensure partners received the ordered stocks	■ Number of days of delay in commodity order	MCDMCH RH Logistics Coordinator
	PE2.2	Provide technical support to prominent FP advocates	■ Number of meetings (FP advocate best-practices, 2 a year) ■ Number of FP advocacy events attended by FP advocates	MCDMCH FP team
	PE2.3	Prominent FP advocates to attend advocacy meetings with government, donors and partners, internationally, nationally, provincially and at the local level	■ Number of FP advocacy events attended by FP advocates	FP advocates
	PSC3.1	Train logistics trainers	■ Number of trainees (trainers, logistics training)	Coordinated by MCDMCH RH Logistics Coordinator
		Train HCWs in logistics management, including tracking data, calculating monthly consumption and ordering stock	■ Number of trainees (HCWs, logistics training)	Coordinated by MCDMCH RH Logistics Coordinator

2016

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
Q1 2016	D1.2	Prepare, produce, and broadcast radio spots, radio serial drama programs and TV programs on FP	■ Number of communications produced (radio spots, 4 a year; radio dramas, 36 a year; TV episodes, 4 a year) ■ Number of communications disseminated (radio spots, 3650 a year; radio dramas, 720 a year; TV episodes, 8 a year)	MCDMCH communications team
		Orient, encourage, and incentivize media groups to support a multimedia FP campaign to increase media	■ Number of trainees (media personnel, FP reporting, 20 a year)	MCDMCH Principal FP Officer

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		awareness, analytical and reporting capacity for FP	■ *Number of media hits on FP (articles in print and online, TV broadcasts, radio broadcasts)* ■ Number of meetings (press conferences on FP issues, 2 a year) Number of awards (to media journalists, 3 a year)	
	D2.2	Identify, select and recruit community FP change champions	■ Number of trainees (community FP promoters, 10 a year per district) ■ Number of community FP promoters trained	Provincial- and district-level FP coordinators
		Train and deploy recruited FP promoters at the district level		Provincial-level FP coordinators in coordination with MCDMCH Principal FP Officer
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA 9.1	Roll out program by training CHAs	■ Number of trainees (trainers, CHA on implants) ■ Number of trainees (CHAs, implant provision, ~300)	MCDMCH
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
	SMC3.1	Train health facility level supervisors in FP supervision	■ Number of trainees (heatl facility supervisors, FP supervision, 300 a year)	
	SMC3.2	Supervise semi-annually from provincial level to districts	■ Number of supervisory visits conducted (to districts, semi-annually)	Provincial-level FP coordinators
		Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre In Charges
	SMC4.3	Hold semi-annual review meetings to revise progress on FP plan at central level	■ Number of meetings (national FP review, 2 a year)	MCDMCH MCH Deputy Director with support from full FP team
		Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
Q2 2016	D1.4	Celebrate World Population Day	■ Number of community mobilization events (health campaigns, 6)	MCDMCH Principal FP Officer
	SDA5.1	Train clinical instructors and nursing tutors (from each of the nursing and medical schools) per year in LARC practical skills	■ Number of trainees (tutors and clinical instructors, trainer of LARC methods, 40-80 a year)	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
		Evaluate performance of the mini clinics and plan for scale-up of the initiative	■ Number of meetings (FP TWG sub-committee on Mini-clinics) ■ Number of documents produced (recommendations on mini-clinics)	MCDMCH Principal FP Officer
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review	MOH & MCDMCH RHCS Coordinators

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			meeting, 4 a year)	
	F1.1	Advocate with key stakeholders (MOF, MOH, and parliamentarians)	■ Number of documents produced (policy brief on FP budgeting) ■ Number of meetings (advocacy to parliamentarians, 1 a year) ■ Amount of FP budget lines (MCDMCH, for FP management/programming ; MOH, for FP commodities; provincial level; district level)	MCDMCH RH specialist, with support from policy advocacy group
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre in Charges
	SMC4.3	Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
Q3 2016	D1.4	Integrate FP into existing health campaigns	■ Number of community mobilization events (health campaigns, 6)	MCDMCH Principal FP Officer and MCDMCH FP specialist
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise annually from central level to provinces	■ Number of supervisory visits conducted (to provinces, annually)	MCDMCH Chief FP Officer
		Supervise semi-annually from provincial level to districts	■ Number of supervisory visits conducted (to districts, semi-annually)	Provincial-level FP coordinators
		Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least	Health centre in Charges

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			quarterly)	
	SMC4.3	Hold semi-annual review meetings to revise progress on FP plan at central level	■ Number of meetings (national FP review, 2 a year)	MCDMCH MCH Deputy Director with support from full FP team
		Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
Q4 2016	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold annual forecasting and quantification workshops	■ Number of meetings (forecasting and quantification workshop, 1 a year) ■ Number of documents produced (annual forecast and procurement plan, 1 a year) ■ Percentage of procurement plan financed	MOH & MCDMCH RHCS Coordinators
		Create national , cross sector supply plan and procure FP commodities		MOH & MCDMCH RHCS Coordinators
		Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre in charges
	SMC4.3	Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
2016	D2.1	Identify and select FP change champions via consultations between MCDMCH, the National FP Technical Working Group, and other stakeholders	■ Number of trainees (national FP change champions, 3-5 a year)	MCDMCH Principal FP Officer
	D3.1	Train peer educators to manage AYSRH clubs	■ Number of active outreach groups (AYSRH clubs in youth centres, 50 a year) ■ Number of trainees (teachers, peer educator trainers and mentors, 60 a year) ■ Number of trainees (peer educators and youth CBDs, 100 a year)	MCDMCH
	SDA2.3	Conduct pilot to assess the feasibility and safety of clinical officers conducting tubal ligations	■ Inclusion in FP TWG agenda (Clinical officer BTL pilot)	MCDMCH
	SDA3.1	Train FP Trainers in each province	■ Number of trainees (trainers, FP for HCWs, 40 a year)	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA3.2	Train CBD and peer educator trainers in each province	■ Number of trainees (trainers, CBD and peer educators, 40 a year)	Trainers, coordinated by MCDMCH Chief FP Officer with support from MCDMCH Principal FP Officer
	SDA4.1	Train a cadre of HCWs annually in LARC, to ensure sufficient LARC providers at all health centres and hospitals	■ Number of trainees (HCWs, LARCs, 500 a year) ■ Number of mentorship visits conducted (HCWs trained in LARCs, 500	Trainers, coordinated by MCDMCH Chief FP Officer

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			year)	
	SDA4.2	Conduct mentorship visits in FP for HCWs annually	▪ Number of mentorship visits conducted	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA7.2	Train 300 Community Based Distributors (CBDs) a year in FP methods on average , to have on average 4 CBDs per health care centre	▪ Number of trainees (CBDs, FP methods, 300 a year)	Trainers, coordinated by MCDMCH Principal FP Officer
		Provide follow-up and supervision of CBDs	▪ Number of mentorship visits conducted (CBDs, 300 a year)Number of providers offering FP (active CBDs)	Trainers, coordinated by MCDMCH Principal FP Officer with support from district-level FP coordinators
	PE2.2	Coordinate national prominent FP advocates through bi-annual meetings to share best practices in advocacy and lessons learnt from FP advocacy	▪ Number of meetings (FP advocate best-practices, 2 a year) ▪ Number of FP advocacy events attended by FP advocates	MCDMCH RH Specialist
	SMC2.1	Pilot mobile -technology to track contraceptive stocks at Health facility level (SMS applications)	▪ Number of documents produced (report on M-Track digital technology pilot, 1)	MCDMCH RH Logistics Coordinator and MSL
Ongoing	D1.2	Establish and facilitate radio listening groups building on established SMAGs	▪ Number of documents produced (discussion guidelines, 1) ▪ Number of active outreach groups (radio listening groups, 2400)	MCDMCH
	D3.1	Support the roll-out of the new adolescent SRH curriculum in schools	▪ SRH public school education curriculum corresponds to Measure Evaluation PRH "best practices" ▪ Number of meetings (FP TWG sub-committee on Adolescent SRH Curriculum)	FP TWG
	D3.2	Brief organizations through in-person meetings and connect to partners	▪ Number of initiatives (incorporating FP into youth development activities, 2 a year)	MCDMCH
	SDA2.1	Coordinate training plan	▪ Number of documents produced (Finalized National FP training plan, 1)	MCDMCH Chief FP Officer, and FP TWG sub-committee on In-Service Training
	SDA3.3	1. Train 6 dedicated FP in-service trainers to pilot dedicated trainer model	▪ Number of trainees (dedicated trainers, FP for HCW, 12)	Coordinated by MCDMCH
	SDA6.1	Trained dedicated FP midwives (*SDA4.3*) provide the full package of non-permanent FP methods at	▪ Number of providers offering FP (dedicated midwives, 1 per district)	Dedicated midwives, coordinated by the district-level FP

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		health facilities		coordinators
		Dedicated FP providers' outreach locations and schedule changes over time as HCW shortage is alleviated in Zambia	■ Number of mentorship visits conducted (dedicated midwives)	Dedicated midwives, coordinated by the district-level FP coordinators
	SDA8.3	Advocate with corporations to fund FP at the national level through corporate social responsibility initiatives	■ Number of meetings (advocacy with donors, 15) ■ Number of PPPs established (FP) ■ Amount of financial contributions (FP programs, ZMW)	FP TWG
	PSC2.1	Conduct post market surveillance on contraceptives	■ Percentage of contraceptive commodity shipments quality tested	MSL
	PSC4.2	Ensure supply chain system continues to provide accurate and timely re-stocking of CBDs	■ Percentage of CBDs being restocked monthly or more frequently	MCDMCH RH Logistics Coordinator
		Ensure system to provide FP commodities and consumables to dedicated FP provider outreach teams	■ Outreach teams to order and receive from MSL supplies which are used during outreach ■ HCs to continue to order and receive FP commodities and consumables for routine FP services at HCs	MSL, coordinated by MCDMCH RH Logistics Coordinator
	PSC4.3	Utilize the RH Logistics Coordinator to ensure all districts and facilities are ordering commodities, and to address any pressing concerns	■ Percentage of districts reporting and ordering FP commodities (1 a month, all districts) ■ Percentage of health facilities reporting and ordering FP commodities (1 a month, 26 districts)	MCDMCH RH Logistics Coordinator
	PSC5.1	Update mapping and troubleshoot with facilities whose consumption does not match expectations	■ Number of documents produced (mapping of commodity flow) ■ Number of updates (mapping, 4 times a year)	MCDMCH RH Logistics Coordinator
	PSC 6.1	Ensure partners received the ordered stocks	■ Number of days of delay in commodity order	MCDMCH RH Logistics Coordinator
	PE2.2	Provide technical support to prominent FP advocates	■ Number of meetings (FP advocate best-practices, 2 a year) ■ Number of FP advocacy events attended by FP advocates	MCDMCH FP team
	PE2.3	Prominent FP advocates to attend advocacy meetings with government, donors and partners, internationally, nationally, provincially and at the	■ Number of FP advocacy events attended by FP advocates	FP advocates

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		local level		
	PSC3.1	Train logistics trainers	■ Number of trainees (trainers, logistics training)	Coordinated by MCDMCH RH Logistics Coordinator
		Train HCWs in logistics management, including tracking data, calculating monthly consumption and ordering stock	■ Number of trainees (HCWs, logistics training)	Coordinated by MCDMCH RH Logistics Coordinator

2017

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
Q1 2017	D1.2	Prepare, produce, and broadcast radio spots, radio serial drama programs and TV programs on FP	■ Number of communications produced (radio spots, 4 a year; radio dramas, 36 a year; TV episodes, 4 a year) ■ Number of communications disseminated (radio spots, 3650 a year; radio dramas, 720 a year; TV episodes, 8 a year)	MCDMCH communications team
		Orient, encourage, and incentivize media groups to support a multimedia FP campaign to increase media awareness, analytical and reporting capacity for FP	■ Number of trainees (media personnel, FP reporting, 20 a year) ■ *Number of media hits on FP (articles in print and online, TV broadcasts, radio broadcasts)* ■ Number of meetings (press conferences on FP issues, 2 a year) ■ Number of awards (to media journalists, 3 a year)	MCDMCH Principal FP Officer
	D1.3	Produce and distribute print materials (posters, IEC, BCC materials) to all clinics, public places and training centers	■ Number of communications produced (posters, flyers, brochures, fact sheets, in 6 languages) ■ Number of communications disseminated	MCDMCH communications team
	SDA2.1	Develop a national training plan to execute high-impact, decentralized, cost-effective training on FP in coordination with the National Health Training Plan under review by MOH	■ Number of documents produced (Finalized National FP training plan, 1)	MCDMCH Chief FP Officer
		Review and finalize plan with stakeholders		FP TWG
		Disseminate training plan		MCDMCH Chief FP Officer
	SDA8.1	Provide permanent contraception days at health centres with	■ Number of outreach visits (to health centres, 1 per	DHOs with coordination of

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		outreach from district hospital HCWs	health centre per quarter)	district-level FP coordinators
	SDA 9.1	Roll out program by training CHAs	■ Number of trainees (trainers, CHA on implants) ■ Number of trainees (CHAs, implant provision, ~300)	MCDMCH
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
		Procure for ongoing equipment and supply needs and furnish for new facilities	■ Percentage of facilities with full equipment list (FP equipment)	MOH
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise semi-annually from provincial level to districts	■ Number of supervisory visits conducted (to districts, semi-annually)	Provincial-level FP coordinators
		Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre in charges

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
	SMC4.3	Hold semi-annual review meetings to revise progress on FP plan at central level	■ Number of meetings (national FP review, 2 a year)	MCDMCH MCH Deputy Director with support from full FP team
		Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
Q2 2017	D1.4	Celebrate World Population Day	■ Number of community mobilization events (health campaigns, 6)	MCDMCH Principal FP Officer
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC1.3	Approve provincial and district-level objectives in the plan	■ Number of meetings (provincial FP coordinator objective review, 1 a year)	Provincial- and district-level FP coordinators
	SMC2.1	Define indicators to be tracked as part of plan implementation in the executive dashboard	■ Number of documents produced (list of HMIS indicators to track, 1)	TST; 2017 review by MCDMCH FP specialist
		Review the existing M&E data collection tools and make recommendations	■ Number of documents produced (M&E collection tools, 1)	MCDMCH FP specialist
	SMC2.3	Update and review the executive	■ Number of updates (executive dashboard, 1 a	MCDMCH FP

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		dashboard regularly	quarter)	specialist
	SMC3.2	Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre in charges
	SMC4.1	Review progress of plan	■ Number of documents produced (situational analysis, 1; review of plan progress, 1; adolescent SRH assessment, 1; updated implementation plan, 1) ■ Inclusion in FP TWG agenda (mid-term plan review)	MCDMCH FP team and FP TWG
	SMC4.3	Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
Q3 2017	D1.4	Integrate FP into existing health campaigns	■ Number of community mobilization events (health campaigns, 6)	MCDMCH Principal FP Officer and MCDMCH FP specialist
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP	MCDMCH FP specialist

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise annually from central level to provinces	■ Number of supervisory visits conducted (to provinces, annually)	MCDMCH Chief FP Officer
		Supervise semi-annually from provincial level to districts	■ Number of supervisory visits conducted (to districts, semi-annually)	Provincial-level FP coordinators
		Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre in charges
	SMC4.3	Hold semi-annual review meetings to revise progress on FP plan at central level	■ Number of meetings (national FP review, 2 a year)	MCDMCH MCH Deputy Director with support from full FP team
		Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
Q4 2017	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold annual forecasting and quantification workshops	■ Number of meetings (forecasting and quantification workshop, 1	MOH & MCDMCH RHCS Coordinators

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			a year) ■ Number of documents produced (annual forecast and procurement plan, 1 a year) ■ Percentage of procurement plan financed	
		Create national, cross sector supply plan and procure FP commodities	■	MOH & MCDMCH RHCS Coordinators
		Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre in charges
	SMC4.3	Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
2017	D3.1	Train peer educators to manage AYSRH clubs	■ Number of active outreach groups (AYSRH clubs in youth centres, 50 a year) ■ Number of trainees (teachers, peer educator trainers and mentors, 60 a year) ■ Number of trainees (peer educators and youth CBDs, 100 a year)	MCDMCH
	SDA4.1	Train a cadre of HCWs annually in LARC, to ensure sufficient LARC providers at all health centres and hospitals	■ Number of trainees (HCWs, LARCs, 500 a year) ■ Number of mentorship visits conducted (HCWs trained in LARCs, 500 year)	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA4.2	Conduct mentorship visits in FP for HCWs annually	■ Number of mentorship visits conducted	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA7.2	Train 300 Community Based Distributors (CBDs) a year in FP methods on average , to have on average 4 CBDs per health care centre	■ Number of trainees (CBDs, FP methods, 300 a year)	Trainers, coordinated by MCDMCH Principal FP Officer
		Provide follow-up and supervision of CBDs	■ Number of mentorship visits conducted (CBDs, 300 a year)Number of providers offering FP (active CBDs)	Trainers, coordinated by MCDMCH Principal FP Officer with support from district-level FP coordinators
	PE2.2	Coordinate national prominent FP advocates through bi-annual meetings to share best practices in advocacy and lessons learnt from FP advocacy	■ Number of meetings (FP advocate best-practices, 2 a year) ■ Number of FP advocacy events attended by FP advocates	MCDMCH RH Specialist
	SMC1.1	Provide the FP division with necessary ongoing working equipment	■ Numbers of equipment procured (laptops, 4; printers, 3; desks, 2; chairs, 4; bookshelves, 4; vehicle, 1)	MCDMCH FP specialist
Ongoing	D1.2	Establish and facilitate radio listening groups building on established SMAGs	■ Number of documents produced (discussion guidelines, 1) ■ Number of active outreach groups (radio listening groups, 2400)	MCDMCH
	D3.1	Support the roll-out of the new adolescent SRH curriculum in schools	■ SRH public school education curriculum corresponds to Measure Evaluation PRH "best practices" ■ Number of meetings (FP TWG sub-committee on Adolescent SRH	FP TWG

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			Curriculum)	
	D3.2	Brief organizations through in-person meetings and connect to partners	■ Number of initiatives (incorporating FP into youth development activities, 2 a year)	MCDMCH
	SDA2.1	Coordinate training plan	■ Number of documents produced (Finalized National FP training plan, 1)	MCDMCH Chief FP Officer, and FP TWG sub-committee on In-Service Training
	SDA3.3	Train 6 dedicated FP in-service trainers to pilot dedicated trainer model	■ Number of trainees (dedicated trainers, FP for HCW, 12)	Coordinated by MCDMCH
	SDA6.1	Trained dedicated FP midwives (*SDA4.3*) provide the full package of non-permanent FP methods at health facilities	■ Number of providers offering FP (dedicated midwives, 1 per district)	Dedicated midwives, coordinated by the district-level FP coordinators
		Dedicated FP providers' outreach locations and schedule changes over time as HCW shortage is alleviated in Zambia	■ Number of mentorship visits conducted (dedicated midwives)	Dedicated midwives, coordinated by the district-level FP coordinators
	SDA8.3	Advocate with corporations to fund FP at the national level through corporate social responsibility initiatives	■ Number of meetings (advocacy with donors, 15) ■ Number of PPPs established (FP) ■ Amount of financial contributions (FP programs, ZMW)	FP TWG
	PSC2.1	Conduct post market surveillance on contraceptives	■ Percentage of contraceptive commodity shipments quality tested	MSL
	PSC4.2	Ensure supply chain system continues to provide accurate and timely re-stocking of CBDs	■ Percentage of CBDs being restocked monthly or more frequently	MCDMCH RH Logistics Coordinator
		Ensure system to provide FP commodities and consumables to dedicated FP provider outreach teams	■ Outreach teams to order and receive from MSL supplies which are used during outreach ■ HCs to continue to order and receive FP commodities and consumables for routine FP services at HCs	MSL, coordinated by MCDMCH RH Logistics Coordinator
	PSC4.3	Utilize the RH Logistics Coordinator to ensure all districts and facilities are ordering commodities, and to address any pressing concerns	■ Percentage of districts reporting and ordering FP commodities (1 a month, all districts) ■ Percentage of health facilities reporting and ordering FP commodities (1 a month, 26 districts)	MCDMCH RH Logistics Coordinator
	PSC5.1	Update mapping and troubleshoot with facilities whose consumption does not match	■ Number of documents produced (mapping of commodity flow)	MCDMCH RH Logistics Coordinator

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		expectations	■ Number of updates (mapping, 4 times a year)	
	PSC 6.1	Ensure partners received the ordered stocks	■ Number of days of delay in commodity order	MCDMCH RH Logistics Coordinator
	PE2.2	Provide technical support to prominent FP advocates	■ Number of meetings (FP advocate best-practices, 2 a year) ■ Number of FP advocacy events attended by FP advocates	MCDMCH FP team
	PE2.3	Prominent FP advocates to attend advocacy meetings with government, donors and partners, internationally, nationally, provincially and at the local level	■ Number of FP advocacy events attended by FP advocates	FP advocates
	PSC3.1	Train logistics trainers	■ Number of trainees (trainers, logistics training)	Coordinated by MCDMCH RH Logistics Coordinator
		Train HCWs in logistics management, including tracking data, calculating monthly consumption and ordering stock	■ Number of trainees (HCWs, logistics training)	Coordinated by MCDMCH RH Logistics Coordinator

2018

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
Q1 2018	D1.2	Prepare, produce, and broadcast radio spots, radio serial drama programs and TV programs on FP	■ Number of communications produced (radio spots, 4 a year; radio dramas, 36 a year; TV episodes, 4 a year) ■ Number of communications disseminated (radio spots, 3650 a year; radio dramas, 720 a year; TV episodes, 8 a year)	MCDMCH communications team
		Orient, encourage, and incentivize media groups to support a multimedia FP campaign to increase media awareness, analytical and reporting capacity for FP	■ Number of trainees (media personnel, FP reporting, 20 a year) ■ *Number of media hits on FP (articles in print and online, TV broadcasts, radio broadcasts)* ■ Number of meetings (press conferences on FP issues, 2 a year) ■ Number of awards (to media journalists, 3 a year)	MCDMCH Principal FP Officer,
	SDA3.4	Ensure province has the appropriate equipment for FP trainings, especially LARCs	■ Number of equipment distributed (gynaecological simulator, 25; plastic uterus, 25; plastic arm, 25)	MOH

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise semi-annually from provincial level to districts	■ Number of supervisory visits conducted (to districts, semi-annually)	Provincial-level FP coordinators
		Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre in charges
	SMC4.3	Hold semi-annual review meetings to revise progress on FP plan at central level	■ Number of meetings (national FP review, 2 a year)	MCDMCH MCH Deputy Director with support from full FP team
		Hold quarterly review meetings to revise progress on FP plan at	■ Number of meetings (provincial FP review, 4 a	Provincial-level FP

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		provincial-level level	year per province)	coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
Q2 2018	D1.4	Celebrate World Population Day	■ Number of community mobilization events (health campaigns, 6)	MCDMCH Principal FP Officer
	SDA5.1	Train clinical instructors and nursing tutors (from each of the nursing and medical schools) per year in LARC practical skills	■ Number of trainees (tutors and clinical instructors, trainer of LARC methods, 40-80 a year)	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	F1.1	Advocate with key stakeholders (MOF, MOH, and parliamentarians)	■ Number of documents produced (policy brief on FP budgeting) ■ Number of meetings (advocacy to parliamentarians, 1 a year) ■ Amount of FP budget lines (MCDMCH, for FP management/programming ; MOH, for FP commodities; provincial level; district level)	MCDMCH RH specialist, with support from policy advocacy group
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a	MCDMCH FP specialist

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			quarter)	
	SMC3.2	Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre in charges
	SMC4.3	Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
Q3 2018	D1.4	Integrate FP into existing health campaigns	■ Number of community mobilization events (health campaigns, 6)	MCDMCH Principal FP Officer and MCDMCH FP specialist
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise annually from central level to provinces	■ Number of supervisory visits conducted (to provinces, annually)	MCDMCH Chief FP Officer
		Supervise semi-annually from provincial level to districts	■ Number of supervisory visits conducted (to districts, semi-annually)	Provincial-level FP coordinators
		Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre in charges
	SMC4.3	Hold semi-annual review meetings to revise progress on FP plan at central level	■ Number of meetings (national FP review, 2 a year)	MCDMCH MCH Deputy Director with support from full FP team
		Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
Q4 2018	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold annual forecasting and quantification workshops	■ Number of meetings (forecasting and quantification workshop, 1 a year) ■ Number of documents produced (annual forecast and procurement plan, 1 a year) ■ Percentage of procurement plan financed	MOH & MCDMCH RHCS Coordinators
		Create national , cross sector supply plan and procure FP commodities	■	MOH & MCDMCH RHCS Coordinators

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre in charges
	SMC4.3	Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
2018	D3.1	Train peer educators to manage AYSRH clubs	■ Number of active outreach groups (AYSRH clubs in youth centres, 50 a year) ■ Number of trainees (teachers, peer educator trainers and mentors, 60 a year) ■ Number of trainees (peer educators and youth CBDs, 100 a year)	MCDMCH

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
	SDA4.1	Train a cadre of HCWs annually in LARC, to ensure sufficient LARC providers at all health centres and hospitals	■ Number of trainees (HCWs, LARCs, 500 a year) ■ Number of mentorship visits conducted (HCWs trained in LARCs, 500 year)	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA4.2	Conduct mentorship visits in FP for HCWs annually	■ Number of mentorship visits conducted	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA7.2	Train 300 Community Based Distributors (CBDs) a year in FP methods on average , to have on average 4 CBDs per health care centre	■ Number of trainees (CBDs, FP methods, 300 a year)	Trainers, coordinated by MCDMCH Principal FP Officer
		Provide follow-up and supervision of CBDs	■ Number of mentorship visits conducted (CBDs, 300 a year)Number of providers offering FP (active CBDs)	Trainers, coordinated by MCDMCH Principal FP Officer with support from district-level FP coordinators
	PE2.2	Coordinate national prominent FP advocates through bi-annual meetings to share best practices in advocacy and lessons learnt from FP advocacy	■ Number of meetings (FP advocate best-practices, 2 a year) ■ Number of FP advocacy events attended by FP advocates	MCDMCH RH Specialist
Ongoing	D1.2	Establish and facilitate radio listening groups building on established SMAGs	■ Number of documents produced (discussion guidelines, 1) ■ Number of active outreach groups (radio listening groups, 2400)	MCDMCH
	D3.1	Support the roll-out of the new adolescent SRH curriculum in schools	■ SRH public school education curriculum corresponds to Measure Evaluation PRH "best practices" ■ Number of meetings (FP TWG sub-committee on Adolescent SRH Curriculum)	FP TWG
	D3.2	Brief organizations through in-person meetings and connect to partners	■ Number of initiatives (incorporating FP into youth development activities, 2 a year)	MCDMCH
	SDA2.1	Coordinate training plan	■ Number of documents produced (Finalized National FP training plan, 1)	MCDMCH Chief FP Officer, and FP TWG sub-committee on In-Service Training
	SDA6.1	Trained dedicated FP midwives (*SDA4.3*) provide the full package of non-permanent FP methods at health facilities	■ Number of providers offering FP (dedicated midwives, 1 per district)	Dedicated midwives, coordinated by the district-level FP coordinators
		Dedicated FP providers' outreach	■ Number of mentorship	Dedicated midwives,

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		locations and schedule changes over time as HCW shortage is alleviated in Zambia	visits conducted (dedicated midwives)	coordinated by the district-level FP coordinators
	SDA8.3	Advocate with corporations to fund FP at the national level through corporate social responsibility initiatives	■ Number of meetings (advocacy with donors, 15) ■ Number of PPPs established (FP) ■ Amount of financial contributions (FP programs, ZMW)	FP TWG
	PSC2.1	Conduct post market surveillance on contraceptives	■ Percentage of contraceptive commodity shipments quality tested	MSL
	PSC4.2	Ensure supply chain system continues to provide accurate and timely re-stocking of CBDs	■ Percentage of CBDs being restocked monthly or more frequently	MCDMCH RH Logistics Coordinator
		Ensure system to provide FP commodities and consumables to dedicated FP provider outreach teams	■ Outreach teams to order and receive from MSL supplies which are used during outreach ■ HCs to continue to order and receive FP commodities and consumables for routine FP services at HCs	MSL, coordinated by MCDMCH RH Logistics Coordinator
	PSC4.3	Utilize the RH Logistics Coordinator to ensure all districts and facilities are ordering commodities, and to address any pressing concerns	■ Percentage of districts reporting and ordering FP commodities (1 a month, all districts) ■ Percentage of health facilities reporting and ordering FP commodities (1 a month, 26 districts)	MCDMCH RH Logistics Coordinator
	PSC5.1	Update mapping and troubleshoot with facilities whose consumption does not match expectations	■ Number of documents produced (mapping of commodity flow) ■ Number of updates (mapping, 4 times a year)	MCDMCH RH Logistics Coordinator
	PSC 6.1	Ensure partners received the ordered stocks	■ Number of days of delay in commodity order	MCDMCH RH Logistics Coordinator
	PE2.2	Provide technical support to prominent FP advocates	■ Number of meetings (FP advocate best-practices, 2 a year) ■ Number of FP advocacy events attended by FP advocates	MCDMCH FP team
	PE2.3	Prominent FP advocates to attend advocacy meetings with government, donors and partners, internationally, nationally, provincially and at the local level	■ Number of FP advocacy events attended by FP advocates	FP advocates
	PSC3.1	Train logistics trainers	■ Number of trainees	Coordinated by

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			(trainers, logistics training)	MCDMCH RH Logistics Coordinator
		Train HCWs in logistics management, including tracking data, calculating monthly consumption and ordering stock	■ Number of trainees (HCWs, logistics training)	Coordinated by MCDMCH RH Logistics Coordinator

2019

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
Q1 2019	D1.2	Prepare, produce, and broadcast radio spots, radio serial drama programs and TV programs on FP	■ Number of communications produced (radio spots, 4 a year; radio dramas, 36 a year; TV episodes, 4 a year) ■ Number of communications disseminated (radio spots, 3650 a year; radio dramas, 720 a year; TV episodes, 8 a year)	MCDMCH communications team
		Orient, encourage, and incentivize media groups to support a multimedia FP campaign to increase media awareness, analytical and reporting capacity for FP	■ Number of trainees (media personnel, FP reporting, 20 a year) ■ *Number of media hits on FP (articles in print and online, TV broadcasts, radio broadcasts)* ■ Number of meetings (press conferences on FP issues, 2 a year) ■ Number of awards (to media journalists, 3 a year)	MCDMCH Principal FP Officer
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month)	MCDMCH FP specialist

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise semi-annually from provincial level to districts	■ Number of supervisory visits conducted (to districts, semi-annually)	Provincial-level FP coordinators
		Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre in charges
	SMC4.3	Hold semi-annual review meetings to revise progress on FP plan at central level	■ Number of meetings (national FP review, 2 a year)	MCDMCH MCH Deputy Director with support from full FP team
		Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
Q2 2019	D1.4	Celebrate World Population Day	■ Number of community mobilization events (health campaigns, 6)	MCDMCH Principal FP Officer
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical	■ Number of documents	MCDMCH FP

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		Working Group Meetings	produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre in charges
	SMC4.3	Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
Q3 2019	D1.4	Integrate FP into existing health campaigns	■ Number of community mobilization events (health campaigns, 6)	MCDMCH Principal FP Officer and MCDMCH FP specialist
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review	MOH & MCDMCH RHCS Coordinators

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			meeting, 4 a year)	
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise annually from central level to provinces	■ Number of supervisory visits conducted (to provinces, annually)	MCDMCH Chief FP Officer
		Supervise semi-annually from provincial level to districts	■ Number of supervisory visits conducted (to districts, semi-annually)	Provincial-level FP coordinators
		Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre in charges
	SMC4.3	Hold semi-annual review meetings to revise progress on FP plan at central level	■ Number of meetings (national FP review, 2 a year)	MCDMCH MCH Deputy Director with support from full FP team
		Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
Q4 2019	SDA8.1	Provide permanent contraception	■ Number of outreach visits	DHOs with

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		days at health centres with outreach from district hospital HCWs	(to health centres, 1 per health centre per quarter)	coordination of district-level FP coordinators
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold annual forecasting and quantification workshops	■ Number of meetings (forecasting and quantification workshop, 1 a year) ■ Number of documents produced (annual forecast and procurement plan, 1 a year) ■ Percentage of procurement plan financed	MOH & MCDMCH RHCS Coordinators
		Create national , cross sector supply plan and procure FP commodities	■	MOH & MCDMCH RHCS Coordinators
		Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly)	Health centre in charges

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			■ Percentage of CBDs supervised (at least quarterly)	
	SMC4.3	Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
2019	D2.1	Identify and select FP change champions via consultations between MCDMCH, the National FP Technical Working Group, and other stakeholders	■ Number of trainees (national FP change champions, 3-5 a year)	MCDMCH Principal FP Officer
	D3.1	Train peer educators to manage AYSRH clubs	■ Number of active outreach groups (AYSRH clubs in youth centres, 50 a year) ■ Number of trainees (teachers, peer educator trainers and mentors, 60 a year) ■ Number of trainees (peer educators and youth CBDs, 100 a year)	MCDMCH
	SDA4.1	Train a cadre of HCWs annually in LARC, to ensure sufficient LARC providers at all health centres and hospitals	■ Number of trainees (HCWs, LARCs, 500 a year) ■ Number of mentorship visits conducted (HCWs trained in LARCs, 500 year)	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA4.2	Conduct mentorship visits in FP for HCWs annually	■ Number of mentorship visits conducted	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA7.2	Train 300 Community Based Distributors (CBDs) a year in FP methods on average , to have on average 4 CBDs per health care centre	■ Number of trainees (CBDs, FP methods, 300 a year)	Trainers, coordinated by MCDMCH Principal FP Officer
		Provide follow-up and supervision of CBDs	■ Number of mentorship visits conducted (CBDs, 300 a year)Number of providers offering FP (active CBDs)	Trainers, coordinated by MCDMCH Principal FP Officer with support from district-level FP coordinators
	PE2.2	Coordinate national prominent FP advocates through bi-annual meetings to share best practices in advocacy and lessons learnt from FP advocacy	■ Number of meetings (FP advocate best-practices, 2 a year) ■ Number of FP advocacy events attended by FP advocates	MCDMCH RH Specialist
	SMC4.2	Update objectives or revise activities as needed based on DHS data	■ Number of documents produced (updated objectives, 1; updated implementation plan if	FP TWG

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			needed, 1)	
Ongoing	D1.2	Establish and facilitate radio listening groups building on established SMAGs	■ Number of documents produced (discussion guidelines, 1) ■ Number of active outreach groups (radio listening groups, 2400)	MCDMCH
	D3.1	Support the roll-out of the new adolescent SRH curriculum in schools	■ SRH public school education curriculum corresponds to Measure Evaluation PRH "best practices" ■ Number of meetings (FP TWG sub-committee on Adolescent SRH Curriculum)	FP TWG
	D3.2	Brief organizations through in-person meetings and connect to partners	■ Number of initiatives (incorporating FP into youth development activities, 2 a year)	MCDMCH
	SDA2.1	Coordinate training plan	■ Number of documents produced (Finalized National FP training plan, 1)	MCDMCH Chief FP Officer, and FP TWG sub-committee on In-Service Training
	SDA6.1	Trained dedicated FP midwives (*SDA4.3*) provide the full package of non-permanent FP methods at health facilities	■ Number of providers offering FP (dedicated midwives, 1 per district)	Dedicated midwives, coordinated by the district-level FP coordinators
		Dedicated FP providers' outreach locations and schedule changes over time as HCW shortage is alleviated in Zambia	■ Number of mentorship visits conducted (dedicated midwives)	Dedicated midwives, coordinated by the district-level FP coordinators
	SDA8.3	Advocate with corporations to fund FP at the national level through corporate social responsibility initiatives	■ Number of meetings (advocacy with donors, 15) ■ Number of PPPs established (FP) ■ Amount of financial contributions (FP programs, ZMW)	FP TWG
	PSC2.1	Conduct post market surveillance on contraceptives	■ Percentage of contraceptive commodity shipments quality tested	MSL
	PSC4.2	Ensure supply chain system continues to provide accurate and timely re-stocking of CBDs	■ Percentage of CBDs being restocked monthly or more frequently	MCDMCH RH Logistics Coordinator
		Ensure system to provide FP commodities and consumables to dedicated FP provider outreach teams	■ Outreach teams to order and receive from MSL supplies which are used during outreach ■ HCs to continue to order and receive FP commodities and consumables for routine FP	MSL, coordinated by MCDMCH RH Logistics Coordinator

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			services at HCs	
	PSC4.3	Utilize the RH Logistics Coordinator to ensure all districts and facilities are ordering commodities, and to address any pressing concerns	■ Percentage of districts reporting and ordering FP commodities (1 a month, all districts) ■ Percentage of health facilities reporting and ordering FP commodities (1 a month, 26 districts)	MCDMCH RH Logistics Coordinator
	PSC5.1	Update mapping and troubleshoot with facilities whose consumption does not match expectations	■ Number of documents produced (mapping of commodity flow) ■ Number of updates (mapping, 4 times a year)	MCDMCH RH Logistics Coordinator
	PSC 6.1	Ensure partners received the ordered stocks	■ Number of days of delay in commodity order	MCDMCH RH Logistics Coordinator
	PE2.2	Provide technical support to prominent FP advocates	■ Number of meetings (FP advocate best-practices, 2 a year) ■ Number of FP advocacy events attended by FP advocates	MCDMCH FP team
	PE2.3	Prominent FP advocates to attend advocacy meetings with government, donors and partners, internationally, nationally, provincially and at the local level	■ Number of FP advocacy events attended by FP advocates	FP advocates
	PSC3.1	Train logistics trainers	■ Number of trainees (trainers, logistics training)	Coordinated by MCDMCH RH Logistics Coordinator
		Train HCWs in logistics management, including tracking data, calculating monthly consumption and ordering stock	■ Number of trainees (HCWs, logistics training)	Coordinated by MCDMCH RH Logistics Coordinator

2020

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
Q1 2020	D1.2	Prepare, produce, and broadcast radio spots, radio serial drama programs and TV programs on FP	■ Number of communications produced (radio spots, 4 a year; radio dramas, 36 a year; TV episodes, 4 a year) ■ Number of communications disseminated (radio spots, 3650 a year; radio dramas, 720 a year; TV episodes, 8 a year)	MCDMCH
		Orient, encourage, and incentivize media groups to support a multimedia FP	■ Number of trainees (media personnel, FP	MCDMCH Principal FP Officer

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		campaign to increase media awareness, analytical and reporting capacity for FP	reporting, 20 a year) ■ *Number of media hits on FP (articles in print and online, TV broadcasts, radio broadcasts)* ■ Number of meetings (press conferences on FP issues, 2 a year) ■ Number of awards (to media journalists, 3 a year)	
	D1.3	Produce and distribute print materials (posters, IEC, BCC materials) to all clinics, public places and training centers	■ Number of communications produced (posters, flyers, brochures, fact sheets, in 6 languages) ■ Number of communications disseminated	MCDMCH communications team
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
		Procure for ongoing equipment and supply needs and furnish for new facilities	■ Percentage of facilities with full equipment list (FP equipment)	MOH
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise semi-annually from	■ Number of supervisory	Provincial-level FP

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		provincial level to districts	visits conducted (to districts, semi-annually)	coordinators
		Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre in charges
	SMC4.3	Hold semi-annual review meetings to revise progress on FP plan at central level	■ Number of meetings (national FP review, 2 a year)	MCDMCH MCH Deputy Director with support from full FP team
		Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
Q2 2020	D1.4	Celebrate World Population Day	■ Number of community mobilization events (health campaigns, 6)	MCDMCH Principal FP Officer
	SDA5.1	Train clinical instructors and nursing tutors (from each of the nursing and medical schools) per year in LARC practical skills	■ Number of trainees (tutors and clinical instructors, trainer of LARC methods, 40-80 a year)	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	F1.1	Advocate with key stakeholders (MOF, MOH, and parliamentarians)	■ Number of documents produced (policy brief on FP budgeting) ■ Number of meetings (advocacy to parliamentarians, 1 a year) ■ Amount of FP budget lines (MCDMCH, for FP management/programming; MOH, for FP	MCDMCH RH specialist, with support from policy advocacy group

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			commodities; provincial level; district level)	
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre in charges
	SMC4.3	Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
Q3 2020	D1.4	Integrate FP into existing health campaigns	■ Number of community mobilization events (health campaigns, 6)	MCDMCH Principal FP Officer and MCDMCH FP specialist
	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA10.2	Review current FP equipment needs as part of regular	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		supervisory visits		
	PSC1.1	Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise annually from central level to provinces	■ Number of supervisory visits conducted (to provinces, annually)	MCDMCH Chief FP Officer
		Supervise semi-annually from provincial level to districts	■ Number of supervisory visits conducted (to districts, semi-annually)	Provincial-level FP coordinators
		Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre in charges
	SMC4.3	Hold semi-annual review meetings to revise progress on FP plan at central level	■ Number of meetings (national FP review, 2 a year)	MCDMCH MCH Deputy Director with support from full FP team
		Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at	■ Number of meetings (district FP review, 4 a	District-level FP

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		district level	year per district)	coordinators
Q4 2020	SDA8.1	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	DHOs with coordination of district-level FP coordinators
	SDA10.2	Review current FP equipment needs as part of regular supervisory visits	■ Inclusion in supervisory visits (FP equipment)	District-level FP coordinators
	PSC1.1	Hold annual forecasting and quantification workshops	■ Number of meetings (forecasting and quantification workshop, 1 a year) ■ Number of documents produced (annual forecast and procurement plan, 1 a year) ■ Percentage of procurement plan financed	MOH & MCDMCH RHCS Coordinators
		Create national , cross sector supply plan and procure FP commodities		MOH & MCDMCH RHCS Coordinators
		Hold quarterly forecast review meetings	■ Number of meetings (forecasting review meeting, 4 a year)	MOH & MCDMCH RHCS Coordinators
	SMC1.2	Institutionalize FP Technical Working Group Meetings	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)	MCDMCH FP specialist
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ Number of meetings attended (HIV TWG)	MCDMCH FP specialist
	SMC2.3	Update and review the executive dashboard regularly	■ Number of updates (executive dashboard, 1 a quarter)	MCDMCH FP specialist
	SMC3.2	Supervise quarterly from districts to health centres and health posts	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)	District-level FP coordinators

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
		Supervise monthly from the health centres to CBDs	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)	Health centre in charges
	SMC4.3	Hold quarterly review meetings to revise progress on FP plan at provincial-level level	■ Number of meetings (provincial FP review, 4 a year per province)	Provincial-level FP coordinators
		Hold quarterly review meetings to revise progress on FP plan at district level	■ Number of meetings (district FP review, 4 a year per district)	District-level FP coordinators
2020	D3.1	Train peer educators to manage AYSRH clubs	■ Number of active outreach groups (AYSRH clubs in youth centres, 50 a year) ■ Number of trainees (teachers, peer educator trainers and mentors, 60 a year) ■ Number of trainees (peer educators and youth CBDs, 100 a year)	MCDMCH
	SDA4.1	Train a cadre of HCWs annually in LARC, to ensure sufficient LARC providers at all health centres and hospitals	■ Number of trainees (HCWs, LARCs, 500 a year) ■ Number of mentorship visits conducted (HCWs trained in LARCs, 500 year)	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA4.2	Conduct mentorship visits in FP for HCWs annually	■ Number of mentorship visits conducted	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA7.2	Train 300 Community Based Distributors (CBDs) a year in FP methods on average , to have on average 4 CBDs per health care centre	■ Number of trainees (CBDs, FP methods, 300 a year)	Trainers, coordinated by MCDMCH Principal FP Officer
		Provide follow-up and supervision of CBDs	■ Number of mentorship visits conducted (CBDs, 300 a year)Number of providers offering FP (active CBDs)	Trainers, coordinated by MCDMCH Principal FP Officer with support from district-level FP coordinators
	PE2.2	Coordinate national prominent FP advocates through bi-annual meetings to share best practices in advocacy and lessons learnt from FP advocacy	■ Number of meetings (FP advocate best-practices, 2 a year) ■ Number of FP advocacy events attended by FP advocates	MCDMCH RH Specialist
Ongoing	D1.2	Establish and facilitate radio listening groups building on established SMAGs	■ Number of documents produced (discussion guidelines, 1) ■ Number of active outreach groups (radio listening groups, 2400)	MCDMCH

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
	D3.1	Support the roll-out of the new adolescent SRH curriculum in schools	■ SRH public school education curriculum corresponds to Measure Evaluation PRH "best practices" ■ Number of meetings (FP TWG sub-committee on Adolescent SRH Curriculum)	FP TWG
	D3.2	Brief organizations through in-person meetings and connect to partners	■ Number of initiatives (incorporating FP into youth development activities, 2 a year)	MCDMCH
	SDA2.1	Coordinate training plan	■ Number of documents produced (Finalized National FP training plan, 1)	MCDMCH Chief FP Officer, and FP TWG sub-committee on In-Service Training
	SDA6.1	Trained dedicated FP midwives (*SDA4.3*) provide the full package of non-permanent FP methods at health facilities	■ Number of providers offering FP (dedicated midwives, 1 per district)	Dedicated midwives, coordinated by the district-level FP coordinators
		Dedicated FP providers' outreach locations and schedule changes over time as HCW shortage is alleviated in Zambia	■ Number of mentorship visits conducted (dedicated midwives)	Dedicated midwives, coordinated by the district-level FP coordinators
	SDA8.3	Advocate with corporations to fund FP at the national level through corporate social responsibility initiatives	■ Number of meetings (advocacy with donors, 15) ■ Number of PPPs established (FP) ■ Amount of financial contributions (FP programs, ZMW)	FP TWG
	PSC2.1	Conduct post market surveillance on contraceptives	■ Percentage of contraceptive commodity shipments quality tested	MSL
	PSC4.2	Ensure supply chain system continues to provide accurate and timely re-stocking of CBDs	■ Percentage of CBDs being restocked monthly or more frequently	MCDMCH RH Logistics Coordinator
		Ensure system to provide FP commodities and consumables to dedicated FP provider outreach teams	■ Outreach teams to order and receive from MSL supplies which are used during outreach ■ HCs to continue to order and receive FP commodities and consumables for routine FP services at HCs	MSL, coordinated by MCDMCH RH Logistics Coordinator
	PSC4.3	Utilize the RH Logistics Coordinator to ensure all districts and facilities are ordering commodities, and to address any pressing concerns	■ Percentage of districts reporting and ordering FP commodities (1 a month, all districts) ■ Percentage of health facilities reporting and	MCDMCH RH Logistics Coordinator

Review meeting	Sub-activity	Sub-activity elements	Output Indicators *(quantity)*	Responsible
			ordering FP commodities (1 a month, 26 districts)	
	PSC5.1	Update mapping and troubleshoot with facilities whose consumption does not match expectations	■ Number of documents produced (mapping of commodity flow) ■ Number of updates (mapping, 4 times a year)	MCDMCH RH Logistics Coordinator
	PSC 6.1	Ensure partners received the ordered stocks	■ Number of days of delay in commodity order	MCDMCH RH Logistics Coordinator
	PE2.2	Provide technical support to prominent FP advocates	■ Number of meetings (FP advocate best-practices, 2 a year) ■ Number of FP advocacy events attended by FP advocates	MCDMCH FP team
	PE2.3	Prominent FP advocates to attend advocacy meetings with government, donors and partners, internationally, nationally, provincially and at the local level	■ Number of FP advocacy events attended by FP advocates	FP advocates
As in JSI/ USAID | DELIVER plan	PSC3.1	Train logistics trainers	■ Number of trainees (trainers, logistics training)	Coordinated by MCDMCH RH Logistics Coordinator
		Train HCWs in logistics management, including tracking data, calculating monthly consumption and ordering stock	■ Number of trainees (HCWs, logistics training)	Coordinated by MCDMCH RH Logistics Coordinator

Annex B: Implementation Framework with Full Activity Detail

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
DEMAND (D)							
*D1. Develop and roll out evidence-based, national, multimedia demand creation campaigns *(FP demand generation and behaviour change communication)*	D1.1 Develop a behaviour change communications (BCC) strategy, including messaging and media to be used	Hire a consultant to spend 30 days developing a communications strategy, including effective messaging and channels to use to promote FP	■ Hold initial meetings with key demand creation partners in FP and related areas to understand their messaging needs, resources, and plans; and evaluate past BCC approaches to select a method that is effective and scalable in the Zambian context ■ Develop actionable strategy for communications, with completed messages. Strategy should include: — Appropriate FP messages for communication at the national, provincial and local levels — Messaging that targets existing myths and misconceptions, especially for LARC — Using national spokespeople/influencers as BCC messengers or role models to talk about FP in media campaigns in addition to their own communication venues (e.g. musicians can embed messages about FP in popular songs) — Messaging tailored to women (married, unmarried of all parities), men, and with a focus on reaching adolescents, vulnerable groups, and the economically disadvantaged; based on best practices in Behaviour Change Communication (BCC) — Media to use for communications, including national, provincial and local radio stations, national and provincial TV stations, and media groups — Campaign plans and scheduling, with different messaging over time as priorities in FP shift; tentatively one new campaign every three years as outlined for print materials in D1.2 ■ Review and approve strategy in presentation to regular TWG meetings	Q4 2013	■ Number of docu-ments produced (commu-nications strategy, 1)	Increased knowledge of FP services ■ Heard FP on radio and TV (DHS) ■ FP messages in print (DHS) ■ Acceptability of media messages on FP (DHS) ■ Knowledge of contraceptive methods (DHS) ■ Main reason not to use a method – Knows no source (DHS) ■ Contact of non-users	MCDMCH communications

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
	D1.2 Based on communica-tions strategy, conduct a multimedia national FP demand-creation campaign to provide accurate information, address myths and misconceptions, promote male involvement, and reach vulnerable groups	Prepare, produce, and broadcast radio spots, radio serial drama programs and TV programs on FP	■ Develop plan for program production — Include messaging from the communication strategy, in line with broader communications and ongoing campaigns, as well as integration with key topics, such as safe motherhood and HIV/AIDS — Develop content and scripts for all the episodes — Develop program creation schedule and responsibilities ■ Work with partners and Ministry resources to develop programs, by hiring actors, video and sound editors, and technicians to complete the programs — 30 sec radio spots broadcast daily on 1 national channel and 9 local/district channels (one per major provincial urban area except Lusaka) □ e.g., ZNBC Radio 1, ZNBC Radio 2, ZNBC Radio 4, Radio Phoenix, Q FM, Ichengelo, Radio Christian Voice, Breeze FM — 36 radio serial drama program episodes per year (10 min, weekly, for 9 months); on 20 local/district radio stations — 4 TV episodes per year, e.g., mini-series (30 min, weekly for 1 month); on 2 national TV stations: ZNBC and Muvi TV ■ New materials to be reviewed on a yearly basis and developed as needed to ensure information is up-to-date — One new radio spot a quarter, in English and 7 official languages — New radio drama every year — New TV episodes/ miniseries/ news program yearly — Information videos produced targeting users, to be aired on broadcast television every other year	Annually, developed in Q1 and broadcast all year, starting in 2014	■ Number of communications produced (radio spots, 4 a year; radio dramas, 36 a year; TV episodes, 4 a year) ■ Number of communications disseminated (radio spots, 3650 a year; radio dramas, 720 a year; TV episodes, 8 a year)	with FP providers (DHS)	MCDMCH communications team
		Establish and facilitate radio listening	■ Develop discussion guidelines and episode "talking points" for FP listening groups, to touch on topics such as FP, teenage pregnancy, HIV/AIDS, SRH, maternal health, child health, etc.	Formation of groups in Q4 2014,	■ Number of documents produced (discussion		MCDMCH

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
		groups building on established SMAGs	■ Formation of radio listening groups at community level — Reach out centrally to community radios to broadcast the episodes — Work with the district-level FP coordinators to reach out to form radio listening groups from existing community groups, especially the ~2400 existing SMAGs ■ Identify local literate SMAG leaders to lead each radio listening group, and provide them with *travel compensation and radios, where needed*, written discussion guidelines, *and chitenges* to lead discussion groups	activities ongoing annually around radio programs	guidelines, 1) ■ Number of active outreach groups (radio listening groups, 2400)		
		Orient, encourage, and incentivize media groups to support a multimedia FP campaign to increase media awareness, analytical and reporting capacity for FP	■ Train 20 journalists from media groups and outlets (newspaper, radio, TV) annually in a 1 day training in Lusaka — Include explanation of FP and key concerns related to FP (dispelling common myths and misconceptions) — Provide appropriate messaging on FP, access to FP, cost of FP, side effects, and method choice — Develop a written "press packet" for journalists/media outlets to distribute during the training and to other media groups and outlets ■ The 20 newspaper and media groups should include at least 1 from each major national newspaper *(The Post, Times of Zambia, Daily Mail, etc.)* and from every provincial media source ■ Organize regular press conferences around events, report launches, etc. on FP (target= at least 2 per year) ■ Respond to media requests for information on FP ■ Monitor media coverage, responding to erroneous information on FP and SRH in media outlets ■ Organize annual media awards of 250 ZMW cash or other prize to be given by the MCDMCH at World Population Day to a journalist for the best coverage of FP in each of print, radio, and TV (target= 3 awards per year)	Annually in Q1, beginning in 2014	■ Number of trainees (media personnel, FP reporting, 20 a year) ■ *Number of media hits on FP (articles in print and online, TV broadcasts, radio broadcasts)* ■ Number of meetings (press conferences on FP issues, 2 a year) ■ Number of awards (to media journalists, 3 a year)		MCDMCH Principal FP Off

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
	D1.3 Print FP promotional materials	Produce and distribute print materials (posters, IEC, BCC materials) to all clinics, public places and training centres	■ Revise existing and develop new print materials in line with the communications strategy, including several types of FP messaging depending on the audience — Develop A1 and A3 size posters; pamphlets/ flyers (A4 page double-sided) and booklets/ fact sheets (equivalent 2 A4 pages double-sided) that detail all FP methods with pictures and local language explanation — Develop content targeting women (including married, pregnant and post-partum) and adolescents/youth in 4 campaign topics: □ Promotional materials on FP in general □ Informational materials on FP □ Promotional and informational materials on LARCs specifically □ Promotional and informational materials on FP targeting adolescents and youth specifically — Informational materials on FP should include all methods, their risks and where they are available. LARC messaging in informational materials should be equal in proportion to short-acting messaging — LARC messaging should include information on the types of implants and IUDs available at the clinic level, the benefits of spacing births, the process for inserting and removing LARC, and the free cost of services — Should also include instructional posters for health workers, reminding them of the key steps of LARC procedures such as IUD insertion — Adolescent messaging should include the benefits of spacing births; the importance of FP during sexual encounters for protection against STIs, including HIV, and contraception; importance of delaying marriage, continuing education, and delaying first pregnancy until the body is fully developed; consequences of early undeveloped births, such as fistulas; free availability of FP at specified service delivery	Every three years in Q2 2014, and Q1 thereafter (2014, 2017, 2020)	■ Number of communications produced (posters, flyers, brochures, fact sheets, in 6 languages) ■ Number of communications disseminated		MCDMCH communications team

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
			points – Messaging should be integrated with messaging for other key issues, including safe motherhood, post-abortion care (PAC), HIV and male circumcision – Develop new materials for each campaign, with unified messaging across all communications as in the communications strategy ■ Print sufficient materials to cover all service delivery points and community centres. For each campaign, distribute – Health centre (urban and rural): 2 A1 posters, 500 flyers and 250 fact sheets – Billeting: 10 A3 posters to be posted within 5 km of each urban health centre, and 5 A3 posters to be posted within 5 km of each rural health centre – Health post: 1 A1 poster, 1 A3 poster, 100 flyers and 25 fact sheets – Warehouses/ stores: 1 A3 poster – District health office: 1 A1 poster and 50 fact sheets – Provincial health office: 2 A1 posters and 100 fact sheets – Ministry office: 2 A1 posters, 1 A3 poster, 10 flyers, 10 fact sheets – SMAG: 25 fact sheets/ booklets – Health campaigns: 200 flyers and 100 fact sheets to be used as part of non-FP related health campaigns (i.e., safe motherhood campaigns), *as outlined below* ■ Printed materials for health facilities and distribution to users should be produced in local languages and distributed to each facility based on its language needs – Hire translators to translate selected posters, pamphlets/ flyers, booklets/ fact sheets produced in English into local languages – Translate materials from English into Nyanja, Bemba,				

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
			Tonga,Lozi, Kaonde, Luvale and Lunda, as well as a limited amount of pamphlets/flyers into Braille, to be sent organizations that serve people with disabilities – Coordinate with National AIDS Council to identify strategies for disseminating information on FP to blind women, and other persons with disabilities.				
	D1.4 Health campaigns	Integrate FP into existing health campaigns	■ Ensure health care workers for ongoing health campaigns at the national and community level have print materials and information on FP to distribute as part of normal campaign work – Target health campaigns closely linked to FP, especially Safe Motherhood Week (5 days) but also HIV/AIDS, under 5 immunization, etc. – Use printed materials for distribution and information at campaigns – Provide participating healthcare and district workers with chitenges ■ Coordinate at the central level with MOH and MCDMCH for integration into the messaging of 4 campaign activities yearly in addition to Safe Motherhood Week and World Population Day ■ Put an emphasis on offering FP services at service delivery points – Ensure FP services are offered at all service points during the campaign (i.e., women are not told to come back during "FP times" another day) – Ensure at least one urban health centre in each district has sufficient qualified staff available during the campaign to focus on providing harder-to-access methods, such as implants and IUDs, and promote the availability of these methods as part of the campaign	Annually in Q3, when Safe Motherhood Week occurs	■ Number of community mobilization events (health campaigns, 6)		MCDMCH Principal FP Offic
		Celebrate World Population Day	■ Obtain authority from Cabinet for the addition of World Population Day to the calendar of health activities, including a budget line for the associated costs ■ Celebrate World Population Day yearly at the national level (1	Annually in Q2, starting in 2014			MCDMCH Principal FP Offic

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
			day), placing a focus on FP information and services — Provide participating healthcare and district workers with t-shirts				
D2. Develop and deploy national- -level FP change champions and local level FP promoters, including religious and traditional leaders	D2.1 Establish a network of national FP change champions (spokespeople/ influencers) to promote the acceptability and benefits of FP	Identify and select FP change champions via consultations between MCDMCH, the National FP Technical Working Group, and other stakeholders	■ Convene a special meeting of the FP Technical Working Group meeting to discuss and select national-level FP champions — The MCDMCH will collate a list of champion suggestions from partners and provide a pre-selection of 5 national-level champions for presentation at the meeting, and a majority vote of partners will confirm a champion; with the objective of getting roughly ~3-5 champions in the first year, and selecting 5 more every 3 years ■ The champions should be selected based on — Prominence and popularity in religious and traditional communities — Respect and influence within the Zambian community and internationally — Support for FP and related issues, including maternal and child health more broadly — Diversity in background, tribe, religion, geography, age, etc.	Specially convened FP Technical Working Group meeting in Q4 2013; repeated selection 2016; 2019	■ Number of trainees (national FP change champions, 3-5 a year)		MCDMCH Principal FP Offi
		Recruit, train equip , and deploy national FP change champions	■ Once the shortlist is developed, formally contact the selected champions, explain the champions role, and ask for their support and approval to become champions ■ Orient the 3-5 champions at central level for a 1/2 day meeting, led by a high-level Ministry official, and thank them for their support ■ Solicit help from FP champions on a case-by-case basis, e.g., for inclusion in TV and radio commercials, print ads, and at major events ■ Mobilize resources to support the deployment of FP change champions at community, provincial, and national meetings and events ■ National FP change champions to reach out and attend existing meetings and embed FP and SRHR advocacy and messaging	Q1 2014			MCDMCH RH specialist and MCDMCH Principal FP Offi

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
			within their participation in activities and events, such as World Population Day, community celebrations, religious services, development events at the national level, etc.				
	D2.2 Establish a network of community-level FP promoters, such as community leaders, religious and traditional leaders, local politicians, satisfied FP users	Orient FP coordinators about the FP promoters initiative	■ Write a letter from the MCDMCH to the FP coordinators at the provincial and district levels, explaining the initiative — Role of FP promoters — Soliciting their input on identifying FP promoters at the community-level	Q2 2014	■ Number of meetings (FP coordinator orientation on FP promoters initiative, 1)		MCDMCH Principal FP Offic
		Identify, select and recruit community FP change champions	■ Develop initial list of suggested FP promoters at the community level drawing on connections with national champion selection processes, in particular focusing on existing community, religious and traditional leaders, as well as politicians. Possible sources include: — Zambian Episcopal Conference — Evangelical Fellowship of Zambia — Islamic Society of Zambia — Parliamentary Committee on Health — Parliamentary Committee on Women ■ Reach out to health centres and health posts to identify particularly well-respected and vocal women users, including users of long-acting methods and adolescents/ youth — Aim to identify 1 promoter in each district per year — Focus on areas or groups who are particularly reticent to FP ■ Write a letter from the FP coordinators at the provincial and district levels to the proposed FP promoters, inviting them to take on this important role in this community, and explaining the responsibilities of the role	Q1 2014; Q1 2015; Q1 2016	■ Number of trainees (community FP promoters, 10 a year per district) ■ Number of community FP promoters trained		Provincial- and district-level FP coordinators
		Train and deploy recruited FP promoters at	■ Train each district's new promoter each year at the provincial level in 5 1-day training sessions of 20 individuals each — Have each session run by 1national-level technical and communications trainer (e.g., the same trainer for CBDs and				Provincial-level FP coordinators in coordination with MCDMC Principal FP Officer

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
		the district level	peer educators) with support from the provincial FP coordinator – Train the FP promoters on FP technical knowledge and side effects, for all available methods; religious and traditional messages and myths/ misconceptions in FP; and responding to typical questions from potential users, adolescents and men – Mobilize resources to support the deployment of FP change champions at community and provincial meetings and events – Community FP promoters to reach out and attend existing meetings and embed FP and SRHR advocacy and messaging within their participation in community activities and events, such as community celebrations, religious services, development events and the community such as micro-credit meetings, etc.				
*D3. Fully integrate FP/SRH in schools and other health programs, including SexEd curriculum in and out of schools *(adolescents and youth)*	D3.1 Integrate Adolescent and Youth SRH into the school health program	Support the roll-out of the new adolescent SRH curriculum in schools	■ Keep informed of the roll-out of the adolescent and youth SRH curriculum, as part of regular FP TWG meetings – Attend relevant meetings with MOESVTEE, MOYS, MOH, etc. – Create TWG sub-committee on Adolescent SRH Curriculum to keep track of progress; including MOYS, MOESVTEE, MOH and MCDMCH RH specialist ■ Provide resources as needed and requested – Trainers for training teachers – Revision of teaching materials – Etc.	2014 onwards	■ SRH public school education curriculum corresponds to Measure Evaluation PRH "best practices" ■ Number of meetings (FP TWG sub-committee on Adolescent SRH Curriculum)	Increased knowledge of FP amongst teenagers and youth ■ Knowledge of contraceptive methods, 15-19 year and 20-24 years of age (DHS) ■	FP TWG
		Work with existing	■ Create AYSRH and FP guidelines for AIDS clubs – Modify school AYSRH curriculum to distill key issues which	Q1 2014	■ Number of active		MCDMCH

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
		AIDS clubs in selected secondary schools and colleges to introduce AYSRH components, including FP, under the school health program	could be communicated by peers – Integrate FP within existing guidelines in place for AIDS clubs in schools ■ Review guidelines and identify key secondary schools and colleges to target in a 1 day meeting of MCDMCH, MOESVTEE and key partners – Identify suitable locations, considering in particular locations with a high concentration of adolescents and limited access to other information services – Locations should be expanded throughout the duration of the plan, aiming for the integration of AYRSH with 10 AIDS clubs per year nationally 2014-2016, reaching all provinces by 2016; and 20 AIDS/AYSRH club integrations per year 2017-2020 ■ Establish ASRH clubs in youth (sports) centres and health centres/facilities either independently or in coordination with existing AIDS clubs, as identified by the provincial FP coordinator and in coordinator with the facility leader		outreach groups (FP in AIDS clubs, 10-20 a year)		
		Train peer educators to manage AYSRH clubs	■ Recruit more peer educators as needed for the AYSRH/ AIDS clubs outside of schools ■ For existing AIDS clubs in schools to be combined with AYSRH: – Continue to use existing peer educators to cover AYSRH as well – Train teachers as trainers of youth peer educators, with 2 teacher per districts to update AIDS curriculum with the addition of AYSRH and FP □ Train 60 teachers per year, for 2 years (2014-2016), in 3 5-day sessions of 20 teachers at the central level, with a focus on younger teachers □ Teachers reach out to peer educators to provide them with new materials for bimonthly discussions ■ For new AYSRH clubs in youth (sports) centres and health centres/facilities,	2014-2020 for peer educated, 2014-2016 for teachers	■ Number of active outreach groups (AYSRH clubs in youth centres, 50 a year) ■ Number of trainees (teachers, peer educator trainers and mentors, 60 a year) ■ Number of trainees (peer		MCDMCH

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
			– Reach out to peer groups and influential individuals at sites chosen each year – Train 2 peer educators per site in a 10-day peer educator and CBD training at the provincial level, including leadership building, aiming for 10 peer educators/ youth CBDs trained annually per province – Ensure peer educators/ youth CBDs have access to necessary commodities through the local health centre, and appropriate bimonthly discussion materials for the AYSRH group		educators and youth CBDs, 100 a year)		
	D3.2 Advocate with general youth developme nt organizatio ns on the benefits of involving FP/ SRHR in youth developme nt activities	Brief organizations through in-person meetings and connect to partners	■ MCDMCH and partners to brief general youth development organizations on the benefits of involving FP/ SRHR in youth development activities (programs and trainings on areas such as life skills and employment) ■ Link youth SRHR specialist partners to provide input, materials, training on FP/ SRHR to youth development organizations	Ongoing	■ Number of initiatives (incorporating FP into youth development activities, 2 a year)		MCDMCH
SERVICE DELIVERY AND ACCESS (SDA)							
SDA1. Evaluate the current health system for FP capacity, establish	SDA1.1 Establish the health system capacity to deliver quality FP services by	Develop and pretest an integrated assessment tool	■ Develop an integrated assessment tool; tool should establish status of several elements – Human resource availability, skills and training, especially for LARC – Equipment availability (FP equipment required at service delivery points for each type of FP) – Adolescent and youth friendly service standards	Q4 2013	■ Number of documents produced (Integrated Assessment tool, 1) ■ Research conducted	Improved resource and training allocation in response to known gaps and facility needs	MCDMCH Chief FP Officer

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
mechanisms for ongoing capacity tracking and implement a mechanism for recommendations to be included in government and partner workplans and budgets	conducting a situation analysis in each district		– FP logistics management, including stocks of FP commodities and consumables – Scope of service delivery coverage (e.g. type of FP provide, hours/weeks FP provided, who provides services, etc.) – Volume of each type of method provided during past year – Partner matrix (types of activities and location, down to facility level. If not delivered at facility, location of service delivery and distance to closest facility); information is first collected at the central level and then verified at the district level in this assessment ■ Pre-test the tool in 3 test districts, with support from MCDMCH and FP coordinators ■ Revise and refine assessment tool, based on pre-test results		(assessment of facilities, partners coverage map, gap analysis) ■ Number of documents produced (FP coverage map and partner matrix, 1 per district) ■ Number of meetings (FP TWG sub-committee on Partner Coordination)		
		Use the assessment tool to conduct facility assessments for all districts to identify FP gaps and partner involvement	■ Work with partners and FP coordinators to leverage existing data and relationships to complete assessment tool for at least 50% of all facilities ■ District FP coordinators visit all facilities to perform assessment using existing data ■ Compile results at each district, and analyze data for gaps ■ Ensure district FP coordinators keep the gap analysis and mapping to use as a tool, and they disseminate it to partners and other health officials as needed				
		Update FP partner matrix and coverage map	■ From preliminary high-level partner profiles developed as part of plan detailing, add information on partners that can be collected from the central level ■ As part of the assessment tool, verify this information at the facility level and consolidate partner landscape findings into a district-, provincial- and national-level mapping				
		Disseminate the findings from the	■ Review findings as part of regular TWG meetings – Create TWG sub-committee on Partner Coordination to				MCDMCH

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
		national situation analysis, partner matrix and coverage map	review findings in depth, make recommendations to the broader TWG and implement measures for better coordination amongst partners				
	SDA1.2 Keep track of the providers trained in each district	Update the pre-service national training database to include information about in-service training	■ Work with the General Nursing Council (GNC) to improve the functionality of the pre-service training database so that it can capture in-service training ■ Include information about HCWs trained in LARC in this database, based on data gathered during the assessment and partner training lists ■ Map the availability of HCWs trained in LARC and identify gaps by district, province, and facility level.		■ Number of updates (training database, 1 a year)		District FP coordinator
SDA2. Develop and disseminate the in-service training plan and a single standardized curriculum for each type of service provider including CBDs	SDA2.1 Develop the national FP in-service training plan	Develop a national training plan to execute high-impact, decentralized, cost-effective training on FP in coordination with the National Health Training Plan under review by MOH	■ Kick off initial development at regular TWG meetings to develop the national FP in-service training plan, including mentorship/ follow-up training elements, based on existing in-service training materials already developed – Plan should include details on the types and number of trainings to be held, including training of trainers; and at what level these should be held □ Plan should describe the pool of trainers that will be created, either at the national, provincial or district level □ How these are used, e.g., if there are dedicated trainers who travel □ On-the-job training components and mentorship □ Plan should link directly with MOH National Health Training Plan □ *Costs of training as outlined in this plan will be revised depending on new training activities or innovations included in the training plan, as well as any changes in timing*	Q3 2013, for completion by Q1 2014; revise in 2017	■ Number of documents produced (Finalized National FP training plan, 1)	Coordination and standardization of training amongst all partners 2.	MCDMCH Chief FP Officer With support from MOH

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
			– Further development and costing – Create TWG sub-committee on In-service Training to continue the development of the in-service training plan for keeping partners up to date, on development outside of formal meetings. ■ Determine the need to revise training curricula for doctors and clinical officers, to include vasectomies and mini-laparotomy female sterilisation ■ Revise training plan for need to update and integrate new FP standards, methods or technology at the same time as the plan's midterm review – In 2017 revision, consider how eLearning might be incorporated into the theoretical training to reduce the length of in-person training sessions				
		Review and finalize plan with stakeholders	■ As part of regular FP TWG meetings, orient partners on plan and receive partner feedback ■ Revise and finalize plan based on partner feedback	Q1 2014; Q1 2017 revision			FP TWG
		Disseminate training plan	■ Hold a stakeholder meeting to disseminate and launch the plan, as well as to ask partners to pledge specific support	Q1 2014; Q1 2017 revision			MCDMCH Chief FP Officer
		Coordinate training plan	■ Review ongoing implementation of training plan, including scheduling trainings and trainers' schedules ■ Coordinate with partners to ensure that total targets are met yearly ■ Report annually to the FP TWG on achievements of FP training targets	Ongoing			MCDMCH Chief FP Officer, and FP TWG sub-committee on In-Service Training
	SDA2.2 Finalise and disseminate the standardised in-service FP	Collect and review all existing in-service training manuals	■ Collect all training materials used for in-service FP trainings, inclusive of: – MOH skills update training materials for doctors, clinical officers, nurses, midwives, health care workers and CBDs – MOH in-service training in BTL and vasectomies for clinical	Q3 2013	■ Number of documents produced (FP training manuals, 5)		MOH trainer, with support from MCDMCH Chief FP Officer

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
	training manuals for health care providers and CBDs		officers – MOH in-service training in LARCs for nurses and midwives – MOH in-service trainings for healthcare workers in adolescent SRH – Partner in-service training in BTL and vasectomies for clinical officers – Partner in-service training in LARCs for nurses and midwives – Partner in-service training in injectables for CBDs				
		Conduct consensus building meeting with key stakeholders to choose one national FP training manual for each type of training	■ Hold a one-day meeting with partners to review training manuals based on FP in-service training plan – Build on one existing manual in each category and incorporate key elements from the other manuals – Ensure training manuals include mentorship tool to facilitate with training follow-up and ongoing mentorship – Ensure curriculum at every level includes sufficient AYSRH modules – *Full review of CBD training curriculum, compensation and partner coordination to first be completed in SDA7.1* – Invite all partners involved in in-service training. (50 participants)	Q1 2014	■ Number of meetings (stakeholder consensus on new training manuals,1)		MOH with support from MCDMCH Chief FP Officer
		Conduct one day orientation and launch meeting for FP TWG members	■ Hold a one-day TWG meeting to orient partners on new training manuals and the key changes – Ensure all partners receive an electronic (soft) copy of all training manuals – Ensure partners involved in each type of training receive at least 10 printed (hard) copies of the relevant training manual, with 20 copies provided to each province for trainers, and 25 copies at the national level	Q2 2014	■ Inclusion in FP TWG agenda (orientation to new training manuals)		FP TWG
	SDA2.3	Conduct pilot	■ 3 year pilot in three districts to assess clinical officers and	2014	■ Inclusion in	Decision on	MCDMCH

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
	Evaluate the possibility of expanding the training plan to include no-scapel vasectomy and mini-laparotomy for female sterilisation for clinical officers and doctors	to assess the feasibility and safety of clinical officers conducting tubal ligations	doctors performing mini-laparotomy tubal ligations and vasectomies ■ Revise clinical officer and doctor training curriculum to include mini-laparotomy tubal ligations and vasectomies ■ Conduct training for 30 clinical officers and doctors in no-scapel vasectomy and mini-laparotomy tubal ligations ■ Conduct monthly supervisory visits in the field for the first months of the pilot, followed by quarterly supervisory & monitoring visits ■ Conduct reviews 6 months and 12 months after training completed. ■ Results disseminated bi-annually at regularly scheduled FP TWG meetings ■ TWG to make a recommendation to the PS MCDMCH based on results of the pilot	(training), 2015 - 2016 (pilot)	FP TWG agenda (Clinical officer BTL pilot)	additional accessibility of tubal ligations through clinical officers	
*SDA3. Train the trainers for decentralization of FP service provision training to the provinces *(staff and training)*	SDA3.1 Establish a pool of national and provincial FP trainers, building on existing training pool	Train FP Trainers in each province	■ Conduct training of Trainers (TOTs) workshops – Trainers will belong to a pool of trainers, aiming to eventually have trainers in every district – Five-day training workshop organized by two central MCDMCH and MOH technical staff, using pre-established training materials – Ensure training curriculum includes both theoretical and sufficient practical training for LARC	2013-2016	■ Number of trainees (trainers, FP for HCWs, 40 a year)	FP training decentralized to provincial and district level ■ Size of pool of trainers in each province and district (training database)	Trainers, coordinated by MCDMCH Chief FP Officer
	SDA3.2 Training of trainers for CBDs and peer educators at all levels of care	Train CBD and peer educator trainers in each province	■ Conduct training of CBD and peer educator trainers (TOTs) – Trainers will belong to a pool of trainers, aiming to eventually have trainers in every district – Five-day training workshop organized by two central MCDMCH and MOH technical staff, using pre-established training materials – *Teacher-trainers of peer educators in D3.1 are separate as only provide peer educator training, without distribution of commodities*	2013-2016	■ Number of trainees (trainers, CBD and peer educators, 40 a year)		Trainers, coordinated by MCDMCH Chief FP Officer with support from MCDMCH Principal FP Offic

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
	SDA3.3 Pilot dedicated FP in-service trainers for nurses and midwives	Train 6 dedicated FP in-service trainers to pilot dedicated trainer model	■ Hire retired midwives or trainers to become full-time trainers ■ Conduct training-of-trainer workshop(s) at central-level to cover traditional FP skills, with a bigger emphasis on on-the-job training and mentorship ■ Include these trainers in the normal training pool of trainers, and roll these out in teams of two dedicated trainers in three districts to pilot the dedicated trainer model, to provide 8-day training of theoretical work and clinical demonstrations, with clinical assessment done over a period of 2 weeks in the HCWs' health facility ■ Review progress of dedicated trainer model, assess its impact, costs and feasibility, determine whether and how to scale-up, and review integration in the training plan, as part of the FP plan's mid-term review in 2017	Hire and TOT in Q2 2014 as part of regular TOT, ongoing training as part of existing training activity SDA4.1 until 2017	■ Number of trainees (dedicated trainers, FP for HCW, 12)		Coordinated by MCDMCH,
	SDA3.4 Procure FP training equipment	Ensure province has the appropriate equipment for FP trainings, especially LARCs	■ Procure 10 models for IUD insertion/removal and 10 models for implant insertion/removal for each province, and an additional 10 at central level; to be used in training of trainers and training in LARCs	Q1 2014; 2018	■ Number of equipment distributed (120 pelvic models, 120 plastic arms)		MOH
*SDA4. Train current health providers in comprehensive FP with emphasis on LARC *(staff and training)*	SDA4.1 Train health providers in comprehensive family planning, with emphasis on LARC	Train a cadre of HCWs annually in LARC, to ensure sufficient LARC providers at all health centres and hospitals	■ Using training database, determine number and location of nurses and midwives who require FP training, particularly for LARC – Both at dedicated FP provider outreach sites and general health sites ■ Conduct LARC-focused training workshops – Conduct trainings at the district level – Twelve-day training workshop at the province level with a review on short-term methods, and the majority of training on LARCs (4 days theoretical, 4 days clinical demonstrations,4 days clinical assessment)	Annually, *phasing out over time as will be detailed in the training plan*	■ Number of trainees (HCWs, LARCs, 500 a year) ■ Number of mentorship visits conducted (HCWs trained in LARCs, 500	Increased access to FP services ■ Increased number of LARC providers in all districts (training database) ■ Source of	Trainers, coordinated by MCDMCH Chief FP Officer

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
			■ Post-training mentorship visits, to ensure provider is properly providing the method and does not have any questions ■ Ensure that all nurses and midwives working in post-abortion wards in large hospitals are trained in FP, including LARC ■ Optimize LARC service delivery where LARC is provided as part of routine FP services ■ Through routine supportive supervision, ensure LARC service delivery model best meets the demands of clients with existing facility resources		year)	supply for modern contraceptive methods (DHS) ■ Reasons for discontinuation of contraceptive methods – Access/ availability (DHS) ■ Reason for not using contraception – Knows no source, Lack of access (DHS) ■ Competence of healthcare providers in FP (supervisory reports)	
	SDA4.2 Conduct periodic mentorship updates in general FP for selected trained providers (CBDs, CHAs and HCWs	Conduct mentorship visits in FP for HCWs annually	■ Conduct FP mentorship visits – Refresher training provided on-the-job by higher-trained cadres visiting the facilities – Refresher training also provided by dedicated FP providers (midwives) through mentorship during visits to health centres – Mentorship already built-in as post-training visits by dedicated trainers; these should also mentor other HCWs in the same facility as needed	Annually, *phasing out over time as will be detailed in the training plan*	■ Number of mentorship visits conducted		Trainers, coordinated by MCDMCH Chief FP Officer
	SDA4.3 Train dedicated FP providers, who are trained in and prioritize offering LARCs	Train 1 midwife per district to offer only FP services, primarily long-acting methods like IUDs and implants	■ Develop comprehensive implementation plan for DFPP teams ■ Recruit retired midwives to rejoin the healthcare system as dedicated FP providers (DFPP) ■ Train midwives at provincial level, following standard FP training plans, with special emphasis on developing their mentoring and teaching skills – Train midwives as needed in each province ■ Post-training mentorship visit after training, to ensure midwife is properly providing the method and does not have any questions	Q3 2014 and Q3 2015	■ Number of new staff hired (midwives, 100) ■ Number of trainees (midwives, dedicated FP, 100 a year) ■ Number of mentorship visits conducted (FP dedicated		Trainers, coordinated by MCDMCH Chief FP Officer with support from MCDMCH Principal FP Offic

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
					midwives, 100 year)		
*SDA5. Improve pre-service training for FP, by updating the current curriculum *(staff and training)*	SDA5.1 Strengthen pre-service skills training in LARC	Review and strengthen the FP component in pre-service medical school, midwifery and general nursing curricula	■ Hold a one-day meeting with technical advisors from MCDMCH, MOH,GNC, and HPCZ (30 participants) ■ Review current FP pre-service training — Adjust time programmed for FP skills training and practicals, based on advocacy results — Ensure content includes counselling and training for all methods and options currently available in Zambia, including especially new implants, and (for MDs and clinical officers only) mini-laparotomy for female sterilisation and no-scalpel vasectomy — Ensure the curriculum is in line with the current FP guidelines and includes AYSRH modules — Provide a sufficient number of models for LARC training to each nursing and midwifery school ■ As part of district-level health FP provision and planning, ensure that training dates are advertised to clients by local health facilities as part of regular communications, to ensure there are sufficient numbers of clients available for practical training in insertion and removal of IUDs and implants; work with CBDs to mobilize additional clients for training days ■ Some health care workers may need to travel to regular DFPP sites to conduct sufficient insertions, assisted and supervised by the dedicated provider	Q1 2014	■ Number of meetings (technical review of pre-service training, 1) ■ Number of documents produced (revised pre-service curriculum)	New HCWs, in particular nurses and midwives, are competent in practical FP knowledge , especially in LARC ■ Competence of healthcare providers in FP (supervisory reports)	MOH with support from MCDMCH Chief FP Office
		Train clinical instructors and nursing tutors (from each of the nursing and medical schools) per year in LARC	■ Conduct training of clinical instructors and nursing tutors — Two workshops per year, one for clinical instructors and one for nursing tutors □ In 2014, hold four workshops — Five-day training workshop organized by two central MCDMCH and MOH technical staff, using newly established curriculum training materials — Train 2 trainers from each medical and nursing school total	4 trainings in Q2 and Q3 2014; 2 trainings in Q2 2016, Q2 2018,	■ Number of trainees (tutors and clinical instructors, trainer of LARC methods, 40-80 a year)		Trainers, coordinated by MCDMCH Chief FP Office

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
		practical skills	in each year of training □ 4 medical schools and ~15 nursing schools ■ In 2014, train 4 from each school	and Q2 2020			
	SDA5.2 Improve HCW registration requirements for LARC	Advocate with professional health registration bodies to institute a LARC-related registration requirement	■ Work with General Nursing Council (GNC), Nurses' Association (NA), and Zambian Association of Gynaecologists and Obstetricians (ZAGO) to align revised pre-service training requirements for health professionals with new standards required for national registration – E.g., for initial health registration, a health professional will have inserted 10 IUDs/ 50 implants and medical officers will perform 30 BTLs within a year – Hold a one-day advocacy and review meeting at the central level ■ Review the suggested standards for national registration with the FP Technical Working Group, obtaining input from partners	Q1 2014, in coordination with the pre-service curriculum review	■ Number of new and/or improved registration requirements for health professionals		MCDMCH Chief FP Officer
*SDA6. Utilize a cadre of dedicated FP providers to improve FP provision capacity and provide mentoring to health care workers in FP *(rural and underserved access to FP*	SDA6.1 Support provision of FP services by a GRZ-run dedicated FP provider outreach program	Trained dedicated FP midwives (*SDA4.3*) provide the full package of non-permanent FP methods at health facilities	■ Recruit and train dedicated FP providers (DFPP) *(SDA4.3)* ■ District develops schedule for dedicated FP providers, in coordination with partners who provide this service and facilities in district ■ All UHCs, RHCs and hospitals that are not able to meet demand for LARC using local HCWS will be candidates for this outreach service – Use capacity assessment tool (SDA1) to identify UHCs, RHCs and hospitals that cannot currently meet LARC demand – Facilities receive the midwife one a week, once a month or once a quarter depending on the demand, other trained providers in that facility, and distance – Timing to be on the same day as the facility's under-5 immunization clinic ■ Midwives provide the full package of non-permanent methods, in particular providing LARCs that would not otherwise be available at the facility, and relieving health care workers as	Ongoing, starting once the midwives are trained in 2014	■ Number of providers offering FP (dedicated midwives, 1 per district)	Improved information and access to contraception in health facilities ■ Client logs (dedicated FP providers) ■ Source of supply for modern contraceptive methods (DHS) ■ Informed choice	Dedicated midwives, coordinated by the district-level FP coordinators

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
services)			needed to providers all FP methods ■ Midwives provide practical LARC training and mentoring to HCWs as part of regular visits to improve and retain FP skills ■ Include outreach activities as part of holistic approach to districts, including BCC messaging and community leaders to introduce and support the program ■ Determine and meet transport needs for each outreach team, depending upon location of outreach sites, local geography and terrain — Leverage transport provided by MOH for commodities, consumables and other staff ■ In some cases, purchase of a vehicle may be considered, to be shared between the outreach team and other teams			(DHS)	
		Dedicated FP providers' outreach locations and schedule changes over time as HCW shortage is alleviated in Zambia	■ As additional health care workers are added and are trained in FP and LARCs, the midwives' schedule refocuses away from facilities which are able to meet demand for LARC with local HCWs ■ Midwives provide ongoing mentorship to HCWs as they are trained in FP in LARCs		■ Number of mentorship visits conducted (dedicated midwives)		
*SDA7. Standardize and scale up community-based distribution of FP *(rural and underserve*	SDA7.1 Standardize CBD training and compensation across government and NGOs	Conduct central review of CBD training curriculum, and get government and partners to agree to standardized	■ Create a sub-committee of the FP TWG on CBD Training and Compensation — Members should include all partners currently working with CBDs ■ Build on and revise existing CBD training curriculum and agree to CBD compensation model, in a 2 day meeting with partners taking into account research, their suggestions and modus operandi	Q1 2014	■ Number of meetings (FP TWG sub-committee on CBD Training and Compensation) ■ Number of documents	Increased community-based access to family planning, particularly in rural areas ■ Client logs (CBDs) ■ Source of	FP TWG

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
d access to FP services)		CBD compensation	— CBD training curriculum and materials — Criteria for selecting CBDs — Equipment provided to CBDs (bicycles, raincoats, etc.) — Compensation for travel — Any other compensation, e.g., a stipend for meals or other incentives ■ *Tentatively, in the costing, CBDs are considered to receive a bicycle, gum boots, a raincoat, an umbrella, and transport refund* ■ The guidelines should describe the requirements for CBDs to give injectables once the pilot has been completed, even if these are not yet approved		produced (CBD training curriculum; CBD compensation model)	supply for modern contraceptive methods (DHS) ■ Reasons for discontinuation of contraceptive methods – Access/ availability (DHS) ■ Reason for not using contraception – Knows no source, Lack of access (DHS)	
	SDA7.2 Scale up training of Community Based Distributors in FP methods	Orient provincial and district officials to the CBD program	■ Hold a one-day meeting at the level of each province to explain to provincial and district officials, including FP coordinators — Explain the role of CBDs and what services they can offer — Qualities to be identified in CBDs — Ask for help in identifying potential CBDs	Q2 2014	■ Number of meetings (CBD role, 1 per province)		MCDMCH Principal FP Offic
		Train 300 Community Based Distributors (CBDs) a year in FP methods on average , to have on average 4 CBDs per health care centre	■ Conduct CBD training workshops — One CBD training workshop per year per province, with 30 CBD participants per training; for a total of 300 CBDs trained annually on average □ Train more CBDs in earlier years, in high-priority districts - E.g., Chongwe and Kafue (Lusaka); Mkushi, Kapiri Mposhi and Serenje (Central); Chilubi and Mungwi (Northern); Chinsali and Mafunga (Muchinga); Mansa and Nchelenge (Luapula); Kalomo and Namwala (Southern); Shangombo and Kalabo (Western); Mfuwe and Katete (Eastern); Mpongwe and Fiwale (Copperbelt) — Conduct trainings at the district level, and rotate each year to cover a new district; so that CBDs are trained at their	Annually, starting in 2014	■ Number of trainees (CBDs, FP methods, 300 a year)		Trainers, coordinated by MCDMCH Principal FP Offic

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
			local health centre as much as possible – Four MCDMCH CBD trainers per training workshop, using existing training materials – Ten-day CBD training workshop with an introduction to short-term methods and counselling/referral for long-term methods, not including injectables; expansion to 20-day training if injectables are approved				
		Provide follow-up and supervision of CBDs	■ Follow-up post-training on the progress of CBDs – Complete a 3-day post-training follow-up in each region, 6 weeks after the training, by two trainers – *Monthly supervision of the CBD by the health centre and quarterly supervision by the district are included in SMC4*	Annually, starting in 2014	■ Number of mentorship visits conducted (CBDs, 300 a year)Number of providers offering FP (active CBDs)		Trainers, coordinated by MCDMCH Principal FP Off
	SDA7.3 Complete CBD injectables scale up demonstration, review results and scale-up to the rest of the country	Conduct demonstration of Injectable use by 20 CBDs in each of 3 districts	■ Train 20 existing CBDs in each of the demonstration districts to provide injectables using the MCDMCH's training curriculum established in SDA8.1. The three districts where the demonstration will be conducted will be Mumbwa, Luangwa and Nyimba	Q3 2013	■ Number of trainees (CBDs, injectables 60)		MCDMCH
		Review results of CBD injectables scale-up demonstration	■ Review effectiveness and safety of CBD Injectables program based on last 3 months of scale-up demonstration – New users of injectables in the district, by source of contraceptives – Percentage of existing users switching source from the health post or health centre to the CBD – Qualitative interviews from users of CBD injectables, CBDs themselves and supervisors on their concerns ■ Review any final concerns on injectable use by CBDs as part of	Q4 2013	■ Number of meetings (FP TWG sub-committee on CBD Injectables program) ■ Number of documents produced		FP TWG

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
			regular TWG meetings ■ Create TWG sub-committee on CBD Injectables — Members should include all partners currently working with CBDs — Develop final set of recommendations to advocate for full CBD injectables provision to Ministry — Finalize the roadmap for scale up — Develop any necessary safety guidelines		(recommendations on CBD injectables)		
		Advocate for Policy Change to allow CBDs to distribute injectables	■ TWG to make formal recommendation to PS on way forward with CBDs and Injectables	Q4 2013			FP TWG
		Scale-up CBD injectables to the whole country, once pilot and report approved	■ Train all appropriate existing CBDs in injectables — Supplemental training of 10 days conducted at district level, with health centre-level supervision for an additional 4 weeks ■ Ensure training for all new CBDs includes injectables	2014-2015	■ Number of trainees (existing CBDs, injectables ~1800)		MCDMCH coordinating all partners with CBDs
*SDA8. Expand access to FP services through new access points, including outreach, mini clinics, and public-	SDA8.1 Deliver integrated FP services through outreach from health centres, leveraging dedicated FP providers	Provide permanent contraception days at health centres with outreach from district hospital HCWs	■ Once a quarter or semi-annually (depending on demand), 1 doctor or 1 clinical officer travel with a nurse to assist from the district hospital level to health centre level to provide mini-laparotomy for female sterilisation and vasectomies ■ Schedule is determine ahead of time by the district-level FP coordinators in coordination with district hospitals, and distributed to health centres for information sharing and demand generation ■ Include outreach activities as part of holistic approach to districts, including BCG messaging and community leaders to introduce and support the program; leverage existing	Quarterly starting in 2014	■ Number of outreach visits (to health centres, 1 per health centre per quarter)	Increased domestic sources of FP ■ Client logs (mini-clinics) ■ Source of supply for modern contracept	DHOs with coordination of district-level FP coordinators

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
private partnerships *(rural and underserved access to FP services)*			opportunities in the community, such as gatherings, to mobilize, inform and access the population			ive methods (DHS)	
	SDA8.2 Pilot mini clinics in places where women gather regularly, that provide only FP services in high density urban areas	Conduct site assessments for mini clinics	■ Discuss potential setting and locations as part of regular TWG meetings — Create TWG sub-committee on Mini clinics to identify locations and sites for mini-clinics, meeting biweekly for 3 months or more, as needed ■ Finalize 5 sites for the provision of new pilot mini clinics in Lusaka (e.g., Soweto market), Ndola and Kitwe, e.g., markets in high density urban areas	Q1 2014	■ Number of meetings (FP TWG sub-committee on Mini-clinics)	■ Reasons for discontinuation of contraceptive methods – Access/ availability (DHS) ■ Reason for not using contraception – Knows no source, Lack of access (DHS)New clinics or partnerships (mapping of facilities)	FP TWG
		Develop infrastructure for all 5 mini clinic pilot facilities	■ Rent site or arrange locale for pilot facilities, e.g., tent ■ Renovate, bring in pre-fabricated building or build on facilities as needed	Q2 2014	■ Number of facilities established (mini-clinics, 5)		MCDMCH Principal FP Off
		Equip the mini clinic facilities with basic equipment for FP	■ Determine which services will be provided at the mini clinics ■ Provide basic package of FP equipment, as described in SDA6	Q3 2014			
		Ensure necessary staff for mini clinics	■ Hire nurses (or retired nurses), CBDs and, cleaner for each site ■ Supervise mini clinics as part of District Health Office supervision ■ Coordination supervision through district-level FP coordinator	Q3 2014			
		Ensure mini clinics are incorporated in supply chain system and reporting/ ordering	■ Ensure district/MSL delivers FP commodities (contraceptives and consumables) to the mini clinic ■ Ensure nurse has received refresher training as part of regular logistics training programs	Q4 2014			MCDMCH RH Logistics Coordinator

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
		directly from MSL					
		Evaluate performance of the mini clinics and plan for scale-up of the initiative	■ Consolidate supervision reports from district-level FP coordinators on performance of mini clinics ■ Review results as part of regular TWG meetings — Reconvene TWG sub-committee on Mini clinics to review performance of mini clinics, meeting biweekly for 3 months or more, as needed — Provide input to the annual district-level planning meetings, if the mini-clinics are a success, with expansion to up to 20 mini-clinics, as determined by TWG ■ If approved, include in mid-term plan review and update	Q2 2016	■ Number of meetings (FP TWG sub-committee on Mini-clinics) ■ Number of documents produced (recommendations on mini-clinics)		MCDMCH Principal FP Offic
	SDA8.3 Explore opportunities for additional public-private partnerships	Hold meetings with private stakeholders to identify opportunities to expand access	■ Invite key private stakeholders in Zambia to a specially convened meeting with MCDMCH, MOH and key partners working in social franchises — Mining: First Quantum, Konkola, ZCCM, etc. — Sugar: Kawambwa, Mazabuka, etc. — Coffee and tea: Munali, Kasama, etc. — Infrastructure: Zesco, ZamPost, etc. — Agriculture: Zambeef, etc. — Telecom: Airtel, MTN, Zamtel, ZAMNET, etc. — Banking: First National Bank of Zambia, ZANACO, Stanbic, Cavmont, etc. — Other: Proflight, etc. ■ Discuss opportunities for national, provincial, district and community level partnerships to provide health services in FP — CBDs on plantations, farms, etc. — Social franchises run by GRZ or NGOs — Funding for local facilities, including staff secondment or	Q3 2014	■ Number of meetings (advocacy with donors, 15) ■ Number of PPPs established (FP) ■ Amount of financial contributions (FP programs, ZMW)		MCDMCH Deputy Director, support from RH specialist

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
			training ■ Also encourage provinces and districts to hold local meetings where relevant with large private players ■ Set goal for expanding private FP service delivery, especially in mine hospitals, and follow-up with provincial FP coordinators to determine their progress and how they can be assisted				
		Advocate with corporations to fund FP at the national level through corporate social responsibility initiatives	■ Advocate with corporations through individual meetings with MCDMCH, MOH and key partners at the national level — Funding of specific FP programs, including semi-private programs or clinics at their facilities, and NGO-supported initiatives — Funding of FP commodities and consumables distributed by MLS ■ Develop a mechanism for corporations to make financial or in-kind contributions to MCDMCH, MOH, and MSL	Ongoing, with initial TWG meeting on this in Q4 2014			FP TWG
SDA9. Leverage the expanding CHA program to improve community-level access to FP	SDA 9.1 Expand CHA scope of work to include implant insertions	Explore feasibility and make recommendation	■ Create TWG sub-committee on CHA Implants ■ Review feasibility of expanding CHA program to include the provision of implants — Review lessons learned from other countries — Discuss concerns of CHAs offering implants — Conduct analysis on the impact of implant insertions provided by CHAs, considering growing number of CHAs — Develop a set of recommendations to advocate for full CHA implants provision to the Ministry — Finalize the roadmap for scale-up ■ Present recommendation to FP TWG and MOH for scale up	Q1 2015	■ Number of meetings (FP TWG sub-committee on CHA Implants) ■ Number of documents produced (recommendations on CHA implants)	Increased provision of FP services, including implants, by CHAs ■ Client logs (CHAs) ■ Source of supply for modern contraceptive methods (DHS)	FP TWG
		Adjust policy to reflect recommendations of TWG sub-committee	■ During a regularly scheduled FP TWG, subcommittee to report on feasibility of expansion of CHA program in include provision of implants ■ PS of MCDMCH review decision of TWG, give guidance on way forward	Q3 2015			FP TWG

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
		on feasibility of CHA Implants					
		Revise CHA training curriculum	■ Revise current CHA pre-service training curriculum to include guidance from PS, including the implant insertion module into the curriculum if appropriate, ensuring sufficient clinical practice ■ As part of regular curriculum review processes, strengthen the FP component of CHA curriculum and develop training quality indicators ■ Develop additional in-service training curriculum to train existing CHAs in implant insertion	Q4 2015	■ Number of documents produced (revised CHA curriculum)		MCDMCH
		Roll out program by training CHAs	■ Develop and implement training plan to provide in-service training to existing CHAs and pre-service training to new CHAs — Include pre-service training as part of regular CHA training program and scale-up ■ Orient 4 CHA tutors on the new FP component of curriculum ■ Train the in-service CHAs in 1 session of 30 participants per province per year	Q1 2016 and Q1 2017	■ Number of trainees (trainers, CHA on implants) ■ Number of trainees (CHAs, implant provision, ~300)		MCDMCH
SDA10. Provide and maintain necessary FP equipment	SDA10.1 Equip service delivery points with necessary FP equipment	Procure and distribute FP equipment	■ Based on initial assessment (SDA1.1), compile list of missing FP equipment for hospitals and health centres (e.g., autoclaves, towel drape, forceps, scissors, speculums, privacy screens, explanatory kits, explanatory handbooks) ■ Purchase equipment centrally ■ Distribute equipment to districts; districts distribute to health facilities using district transport	Q1 2014	■ Numbers of equipment procured (FP equipment)	Ensured availability of equipment, infrastructure, and supplies for FP service provision at all FP service delivery points	MOH coordinated by MCDMCH RH specialist
	SDA10.2 Regularly review FP equipment	Review current FP equipment needs as part of regular	■ Update district FP coordinators' supervision checklist to determine the state, quantity and quality of necessary FP equipment and supplies ■ Include in supervisory reports equipment to be replaced due to age, use or because it is missing	Quarterly district supervisory visits	■ Inclusion in supervisory visits (FP equipment)		District-level FP coordinators

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
		supervisory visits					
		Procure for ongoing equipment and supply needs and furnish for new facilities	■ Based on quarterly reports, compile list of missing FP equipment and supplies ■ Purchase equipment and supplies, with an extra stock procured for the central level to be distributed as equipment fails ■ Distribute equipment and supplies to districts; districts distribute to health facilities using district transport	Q1 2017; Q1 2020	■ Percentage of facilities with full equipment list (FP equipment)		MOH
SDA11. Integrate FP services with other health services	SDA11.1 Integrate FP into other health services, particularly HIV, post-partum services, post-abortion care and under-5 immunization	Engage consultant to develop basic package for integration	■ Engage consultant for 10 days to develop basic package of clinical guidelines for ensuring FP referral integration with other health services — HIV, building on FP/HIV service guidelines developed MCDMCH — Post-partum services, in particular the inclusion of post-partum IUDs — Under-5 care, e.g., immunization — Other potential services, e.g., pre- and post-natal care, male circumcision, cervical cancer screening, gender based violence, and STI management	Q4 2013	■ Number of documents produced (clinical guidelines for FP integration) ■ Number of meetings (FP TWG sub-committee on FP Service Integration)	Increased integration of FP with other health services ■ FP acceptors among other health service seekers (client logs) ■ HIV/ AIDS knowledge (DHS)	MCDMCH
	SDA11.2 Integrate FP into post-abortion care	Workshop with key stakeholders to agree on the basic package for integration of FP into other health services, in particular post-abortion care and HIV	■ Review recommendations as part of regular TWG meetings — Create TWG sub-committee on FP Service Integration to review recommendations in depth and agree on next steps — If revision of curriculums or training materials is required, to be done during next cycle	Q1 2014			FP TWG

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
		services					
		Orient officials and trainers to the new integration package	■ Ensure training also focuses on service providers who are already providing post-abortion care ■ Send a letter from MCDMCH to provincial and district level FP coordinators, as well as to all existing trainers, informing them of the change ■ Include FP service integration in any training of trainers (TOT) from now on, as in SDA3.1	Q2 2014			MCDMCH Chief FP Officer
		Work with hospitals which have a post-abortion care ward to integrate provision of FP (including all methods) as part of post-abortion care for all women	■ Identify hospitals and meet with administrative, nursing and physician management ■ Train nurses working in these ward sin full FP, including LARC ■ Equip these wards with FP equipment needed ■ Work with hospitals to implement routine FP counselling for all post-abortion care clients prior to discharge ■ Provide FP services, including LARC, to all post-abortion care clients in ward prior to discharge (if desired)	Q3 2014			MCDMCH RH Specialist
SDA12. Provide targeted services and education to adolescents and youth	SDA12.1 Establish Youth Friendly Service Points in each district	Equip Service Points	■ District level FP focal point to identify rooms in existing government facilities (e.g. sports complexes, administration blocks) that can be set aside for youth services ■ Refurbish room(s) identified for youth friendly services, including with promotional and educational materials ■ Space to be staffed by peer educators who are trained in distributing pills and condoms as described in D3.1	Q3 2014	■ Number of facilities with youth friendly service points established	# of adolescents accessing commodities through peer educators at youth friendly services ■ Client logs (Youth Friendly Service Points) ■ Source of	MCDMCH Principal FP Offic

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
						▪ supply for modern contraceptive methods, ages 15-19 and 20-24 (DHS) ▪ Knowledge of a formal source of condoms among young people (DHS)	
PROCUREMENT AND SUPPLY CHAIN (PSC)							
PSC1. Forecast, quantify and procure FP commodities	PSC1.1 Conduct annual quantification, forecasting and procurement workshops for FP commodities and consumables (for IUDs, implants, tubal ligations, etc.)	Hold annual forecasting and quantification workshops	▪ Hold annual meeting to review annual contraceptive and consumable needs – Collect service estimates from all partners, including NGOs and private facilities sourced through MSL – Collect purchase estimates from all partners, including donors, and partners purchasing their own commodities – Review planned activities that may impact FP uptake, e.g. training or outreach campaigns – Review current stocks and expected incoming orders – Prepare and present initial situation review, identifying gaps in procurement of commodities, if they exist ▪ Follow-up with MOH to confirm budget line for RH commodities, and contraceptives specifically, on an annual basis ▪ Follow-up with interested partners to determine if they can further help to fill the financing gap	Annually in Q4	▪ Number of meetings (forecasting and quantification workshop, 1 a year) ▪ Number of documents produced (annual forecast and procurement plan, 1 a year) ▪ Percentage of procurement	FP commodity security at the central level ▪ Stock-outs of contraceptives and consumables at the central level (quarterly quantification reports)	MOH & MCDMCH RHCS C

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
		Create national , cross sector supply plan and procure FP commodities	■ Procure commodities based on finalized annual commodity procurement plan ■ Ensure all partners procure agreed-upon commodities, including full expenditure of the budget line provided by GRZ through MOH	Annually in Q4	plan financed		MOH & MCDMCH RHCS Co
		Hold quarterly forecast review meetings	■ Hold quarterly meeting to review current contraceptive and consumable stock status, and predicted needs — Review current stocks and expected incoming orders and compare these to original annual forecast developed; prepare and present the situation — Review current forecast and compare to last quarter's usage, by commodity — Update forecasts based on partner activities and any trends in the data — Identify any commodities that may be low in stock and urgently need to arrive; remind partners responsible for these ■ Further follow-up with partners as needed, to ensure orders or additional financing — Prepare proposals for alternative funding sources and contributions	Quarterly	■ Number of meetings (forecasting review meeting, 3 a year)		MOH & MCDMCH RHCS Co
	PSC1.2 Consider co-packing FP consumables with the respective commodities	Review feasibility of prepackaged FP consumables with commodities, either as part of the existing emergency	■ Hold meeting with MSL and partners (e.g., MSI) to review feasibility — Report from situational analysis on frequency of consumable stockouts — Review existing pre-packaging system used by MSI and compare to MSL's essential medicines pack — Decide whether to move forward with pre-packaging and work with MSL to carry it out.	Q2 2014	■ Number of meetings (discussion on prepacked commodities, 1)		MCDMCH RH Logistics Coordinator

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
		medicines pack or separately					
PSC2. Assure the quality of contraceptives	PSC2.1 Support Zambia Bureau of Standards and Medical Stores Limited in assuring quality of contraceptives	Conduct post market surveillance on contraceptives	■ Conduct quality assurance testing on incoming contraceptives — Tests should be conducted randomly on condoms, in coordination with internal standards and testing laboratories — All other contraceptives should be procured from qualified vendors, with external testing prior to shipping	Ongoing	■ Percentage of contraceptive commodity shipments quality tested	High Standard FP commodities available throughout Zambia	MSL
PSC3. Build FP commodity logistics capacity at service delivery level	PSC3.1Train HCWs in logistics and collection of user data	Train logistics trainers	■ Conduct training of logistics trainers		■ Number of trainees (trainers, logistics training)	Efficient process for commodity management, with accurate data for forecasting and ordering ■ Facilities reporting stock levels (monthly orders to MSL)	Coordinated by MCDMCH RH Logistics Coordinator
		Train HCWs in logistics management, including tracking data, calculating monthly consumption and ordering stock	■ Conduct logistics training workshops as done for all health commodities, including FP commodities ■ 5-day formal training using 3 trainers with post-training mentorship and supervisory visits, prioritizing newly trained districts/ facilities or those with issues reporting ■ Train 2000 HCWs by 2015; and another 1000 HCWs by 2020		■ Number of trainees (HCWs, logistics training)		Coordinated by MCDMCH RH Logistics Coordinator
*PSC4. Ensure last-mile distribution	PSC4.1 Support decentralization of Medical	*Procure distribution trucks, for the regional*	■ Procure 1 truck and 2 4x4s for each of the 6 regional hubs to aid in distribution of commodities, in addition to existing transportation equipment	2013-2015	■ Number of vehicles procured (trucks, 6;	FP commodity availability at service delivery	MSL

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
of contraceptives to facilities not currently reached directly by MSL *(stockouts at service delivery points)*	Stores Limited to the provinces *[Only percentage related to FP commodities considered part of overall FP budget, as still critical to plan implementation]*	*hubs*			4x4s, 12)	points	
		Orient provincial hub managers, district logistics officers and health centre leads in the new MSL system	■ As per MSL's roll-out strategy, do on–the-job training with district pharmacists and HCWs in facilities as the hub-system is rolled out	2013-2015	■ Number of trainees (pharmacists and HCWs, new logistics system)	■ Stock-outs of contraceptives and consumables at the service delivery point level (monthly orders, quarterly supervisory reports)	MSL
	PSC4.2 Distribute products at the sub-regional level: districts, health centres, health posts and CBDs	*Support infrastructure for the distribution of contraceptives at sub-district level for facilities not yet reached by MSL decentralization [Only percentage related to FP commodities considered part of overall FP budget, as still critical to plan*	■ Procure 4x4s for rural districts and districts with significant problems with distribution from the district level to the health centres and posts, to focus primarily on the distribution of contraceptive commodities – Drivers, gas and maintenance will be covered by the district directly	2014	■ Number of vehicles procured (4x4s)		MSL

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
		implementation]					
		Ensure supply chain system continues to provide accurate and timely re-stocking of CBDs	■ The CBD supervisor also supervises and ensures the distribution of commodities to CBDs, by working closely with the logistics officer at the health centre — Health centre logistics officer compiles CBD usage data to forecast needs and order necessary commodities — CBDs retrieve commodities on a monthly basis; if they live <5km from a health centre they come to pick them up), and >5km are delivered to them directly or to the closest health post by the health centre (e.g., using motorcycle, vehicle, or other means of transportation)		■ Percentage of CBDs being restocked monthly or more frequently		MCDMCH RH Logistics Coordinator
		Ensure system to provide FP commodities and consumables to dedicated FP provider (DFPP) outreach teams	■ Outreach teams to order and receive from MSL supplies which are used during outreach; any issues to be addressed by the RH Logistics Coordinator as part of regular responsibilities ■ HCs to continue to order and receive FP commodities and consumables for routine FP services at HCs	Ongoing	■ Percentage of outreach teams being restocked monthly or more frequently		MSL, coordinated by MCDMCH RH Logistics Coordinator
	PSC4.3 Institute a RH Logistics Coordinator	Utilize the RH Logistics Coordinator to ensure all districts and facilities are ordering commodities, and to address any pressing concerns	■ Have the newly-created RH Logistics Coordinator ensure all districts in the non-EMLIP system and all facilities in the EMLIP system are reporting stocks and ordering FP commodities and consumables — Email or call facilities on an individual basis to ensure this is the case — Flag problem facilities or districts and ensure these are particularly paid attention to during supervision, and are prioritized for logistics training ■ Provide districts and facilities with this person's contact information to help them in the case of a pressing concern	Ongoing	■ Percentage of districts reporting and ordering FP commodities (1 a month, all districts) ■ Percentage of health facilities reporting and ordering FP		MCDMCH RH Logistics Coordinator

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
			– RH commodity security coordinator will work with MSL, MSL hubs and district pharmacists – In an extreme situation, the RH Logistics Coordinator will coordinate with the district pharmacist and the district-level FP coordinators to see if commodities can be carried as part of partner visits, or even redistributed across facilities		commodities (1 a month, 26 districts)		
PSC5. Proactively identify and address challenges with distribution and requisition of FP commoditie s	PSC5.1 Use commodity mapping to troubleshoot distribution challenges	Conduct mapping of contraceptive commodities at every level	■ Use data from MSL, MCDMCH, HMIS and relevant partner indicators to track the flow of commodities from central to facility level, tracking contraceptives dispensed to users and consumption where possible	Q2 2014	■ Number of documents produced (mapping of commodity flow) ■ Number of updates (mapping, 4 times a year)		MCDMCH RH Logistics Coordinator
		Update mapping and troubleshoot with facilities whose consumption does not match expectations	■ Update mapping regularly using supervisory reports from districts and provinces ■ Use the HR training database to identify facilities that have trained health care workers but are not requesting specific FP commodities, especially implants and IUDs ■ Follow up with these health facilities and District pharmacists to troubleshoot	Ongoing			MCDMCH RH Logistics Coordinator
PSC6. Support partners in FP commodity procuremen t and distribution	PSC 6.1. Streamline process by which partners access MSL stock	Create clear and quick request, approval, and dispensing process for partners to receive FP commodities from MSL	■ Meet with partners and MSL to understand how partners can currently order, receive and collect FP commodities from MSL; and determine both sides' needs ■ Provide recommendations to the FP TWG for partner feedback, review and approval ■ Ensure this process works both in the new hub-based system rolled out by MSL and in the interim; as well as in both districts and facilities with and without EMLIP	Q2 2014	■ Number of days of delay in commodity order	Commodity security for partners at central level	MCDMCH RH Logistics Coordinator and MSL
		Ensure partners received the	■ Stay aware of order partners have submitted for FP commodities through MSL ■ Follow-up with MSL to ensure partner commodities are	Ongoing			MCDMCH RH Logistics Coordinator

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
		ordered stocks	delivered when and as ordered				
POLICY AND ENVIRONMENT (PE)							
PE1. Include FP in relevant national policies	PE1.1 Ensure inclusion of FP messages in relevant national policy documents, implementation plans that determine budget allocations	Engage consultant to review relevant government policy documents for sections addressing FP	■ MCDMCH to make request to partners for provision of a consultant for 30 days for the purpose of reviewing national policy documents for linkages with FP policy ■ Consultant will review government policy relevant to FP and identify existing FP policy, policy which needs to be updated, and missing policy. Policies and documents to be reviewed will include, but not be limited to the following: — National Health Strategic Plan (NHSP) — Maternal and Newborn Care Health (MNCH) roadmap — Ante-, pre-, post-natal, post-partum and post-abortion care (PAC) — Adolescent health guidelines — AIDS/HIV documents	Q1 2014	■ Number of documents produced (review of national policy documents)	■ Messages on FP included in all major national policy documents ■ The case for FP strengthened within the national health and development agenda • Increased resources for FP within the health sector (including allocations to FP within HIV programming) and embedded within national	MCDMCH guidance
		Conduct a consultation meeting to reach consensus on inclusion of FP in major national policy documents, strategies and plans	■ Review findings as part of regular TWG meetings — Create TWG sub-committee on FP policy to review findings in depth and make recommendations to the broader TWG — Implement changes □ For MCDMCH documents, update during the next cycle □ For other ministries, engage with department directors to identify timelines for new policies and policy review and structure a calendar for engagement through appropriate channels (informal, via MCDMCH Permanent Secretary, Parliament Committee on Health, through securing formal invitations to planning/budgeting meetings, etc.)	Q2 2014	■ Number of meetings (FP TWG sub-committee on FP policy) ■ Number of documents produced (revised national policies)		FP TWG

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
						development budgets	
PE2. Create a consortium of prominent FP advocates	PE2.1 Create a consortium of prominent FP advocates	Identify and recruit prominent FP advocates via consultations between MCDMCH, the National FP Technical Working Group, and other stakeholders	■ Convene a special meeting of the FP Technical Working Group meeting to discuss and select national-level prominent FP advocates — The MCDMCH will collate a list of suggestions from partners and provide a pre-selection of 5 national-level champions for presentation at the meeting, and a majority vote of partners will confirm an advocate; with the objective of getting roughly ~3-5 advocates in the first year, and selecting 5 more every 3 years ■ The prominent FP advocates should be selected based on — Prominent leadership, e.g. religious and traditional leaders, politicians at national levels including parliamentarians, and business leaders — Respect and influence within the Zambian community and internationally — Support for FP and related issues, including maternal and child health more broadly — Diversity in background, tribe, religion, geography, age, etc.	Q1 2014	■ Number of trainees (FP advocates, 3-5 a year) ■ Inclusion in FP TWG agenda (FP advocates)	FP positioned as a major contributing factor to Zambia's health and development goals ■ Acceptability of media messages on FP (DHS)	MCDMCH with FP TWG support
	PE2.2 Coordinate prominent FP advocates and scale up best practices in advocacy	Coordinate national prominent FP advocates through bi-annual meetings to share best practices in advocacy and lessons learnt from FP advocacy	■ Hold bi-annual meetings (constituted from TWG at the national level) to coordinate the selection and activities of prominent FP advocates ■ Coordination of FP change champions and prominent FP advocates in each bi-annual meeting (constituted from TWG at the national level) ■ Track and coordinate advocacy opportunities at national and international levels and pursue invitations for prominent FP advocates to attend and speak	Biannual	■ Number of meetings (FP advocate best-practices, 2 a year) ■ Number of FP advocacy events attended by FP advocates		MCDMCH RH Specialist

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
		Provide technical support to prominent FP advocates	■ Support specific activities of prominent FP advocates, including providing technical support on FP issues ■ Parliamentary Committee on Health: — Make presentations to the committee — Write memorandums on policy issues — Work with the committee to support to develop policy briefs/facts sheets on the case for investing in FP for distribution to parliament ■ First Lady — Provide technical support and information for First Lady's speeches and attendance at national and international events ■ Business leaders — Provide information and advocacy talking points on private-public partnerships	Ongoing			MCDMCH FP team
	PE2.3 Support consortium of prominent FP advocates to attend key advocacy meetings	Prominent FP advocates to attend advocacy meetings with government, donors and partners, internationall y, nationally, provincially and at the local level	■ Prominent FP advocates to reach out and attend existing meetings and events (as identified above) and embed FP and SRHR advocacy and messaging within their participation in activities and events	Ongoing			FP advocates
PE3. Revise the FP guidelines	PE3.1 Clarify FP guidelines for those under	Identify barriers adolescent access to FP	■ Use regular TWG meetings to review suggestions on under-16 access to FP services — Age restrictions, if any	Q3 2013	■ Inclusion in FP TWG agenda (under-16	Relevant updated and practical guidelines for FP	FP TWG

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
to address task-shifting and under 16 access	16	in current FP Guidelines	— Special provisions required for the counselling and access of under-16 FP, if any — Parental or guardian consent, if any ■ Lobby MOESVTEE for support of FP programming and guidance on under 16 access, including distribution of contraceptives in schools		access to FP services) ■ Inclusion in FP TWG agenda (task-shifting) ■ Number of meetings (FP guidelines review)	provision, effectively used by healthcare workers ■ Informed choice (DHS) ■ Competence of providers during consultation (supervisory reports)	
		During revision of FP guidelines, ensure wording around under-16 access to contraceptives is unambiguous	■ As part of FP guidelines review, ensure wording of guidelines related to under-16 FP access, and any other adolescent and youth FP issues is as agreed to in TWG, clear, and unambiguous	Q3 2013, as part of FP guidelines review meeting			MCDMCH FP specialist
		Ensure promotion of the new guidelines	■ Ensure new guidelines are fully integrated as part of new provider training in adolescent FP (SDA11) ■ Ensure changes to updated guidelines, including to under-16 care, are highlighted to HCWs when the new guidelines are distributed, including through a 1-2 page briefing document covering major changes and common misunderstandings of the guidelines to accompany full guideline document	Q1 2014			MCDMCH FP specialist
	PE3.2 Advocate for changing FP guidelines for task-shifting	Change the MCDMCH policies to allow CBDs to give injectables, and CHAs to provide	■ Use regular TWG meetings to review suggestions on task-shifting and address concerns of decision makers preventing inclusion in the FP guidelines — Propose CBDs be allowed to give injectables, with proper training and supervision from a health centre, and that this be provisionally tested in a 3-month demonstration — Propose CHAs be allowed to provide implant insertions and	Q3 2013, as part of regular TWG meetings and the FP guideline			FP TWG

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
		implants	that this be provisionally tested in a 6-month pilot	s review meeting			
FINANCING (F)							
F1. Advocate for increased funding for FP, from the government and donors	F1.1 Create an official budget line for FP in the sector budgets of the MCDMCH and MOH as part of the national budget managed by the MOF	Advocate with key stakeholders (MOF, MOH, and parliamentarians)	■ Prepare a policy brief for the Parliamentary Committee on Health on the importance of FP allocations within the budgets of the MOH and MCDMCH ■ Host a meeting with parliamentarians and partners to advocate on the importance of parliament in protecting FP line item allocations, and to only endorse a budget from the MOF that includes FP as a specific line item; and once this budget line exists, to increase it ■ Agenda should include – Current costs of FP care and commodities in Zambia – Current government budget support in MoH and MCDMCH and donor/ partner funding – International prioritization of FP, e.g., London Summit on FP and FP2020 – Support for FP from First Lady and other prominent FP advocacy champions – Benefits of FP – Expected cost "savings" by implementing FP, through the impacts of reduced teenage pregnancy, maternal mortality, etc. – Need for a FP-only budget line (rather than RH), and for an FP commodity budget line (rather than RH commodities) ■ MCDMCH and MOH Directors to include FP as budget lines in their respective budgets by September. ■ Engage MOF to ensure that FP budget line in maintained and not removed/rejected from the sectoral budgets. ■ Advocate with parliamentarians to endorse, maintain, and advocate for increases in the FP line items in the budgets for the MOH and MCDMCH.	Q2 2014, Q2 2016, Q2 2018, and Q2 2020	■ Number of documents produced (policy brief on FP budgeting) ■ Number of meetings (advocacy to parliamentarians, 1 a year) ■ Amount of FP budget lines (MCDMCH, for FP management/ programming; MOH, for FP commodities; provincial level; district level)	Increased budget line and national transparency of domestic funding for FP ■ Budget allocation for family planning services (yellow book) ■ Budget allocation for family planning commodities (yellow book)	MCDMCH RH specialist, with support from policy advocacy group

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
	F1.2 Conduct and sustain advocacy targeting development partners and donors to raise level of FP support	Mapping of development partners interested in supporting FP	■ Identify partners potentially interested in FP in Zambia by reviewing the list of partner organizations present in FP — Partners already involved in FP in Zambia, including all members of the TWG — Partners interested or involved in FP in other countries but not yet in Zambia — Partners involved in the London Summit on FP or FP2020 but not yet represented in Zambia — Private companies/organizations supporting health services in Zambia ■ Write a letter from the MCDMCH PS in coordination with the FP2020 in-country working group to existing and potential partners — Informing them of the plan's existence, and offering to meet and present them the plan — Inviting partners to future meeting for repositioning FP	Q4 2013	■ Number of meetings (advocacy to partners, 1)	Increased donor financial and partner implementation support to FP ■ Donor project budgets ■ Donor financing of FP commodities (annual forecasting meetings)	MCDMCH Principal FP Offic
		Organize a meeting with FP development partners for repositioning of FP, inviting donor commitments	■ Hold a one-day advocacy meeting with key FP development partners — Invite all partners previously identified as potentially being interested in FP in Zambia — Have high level officials host the advocacy day, including the Minister of Community Development, Mother and Child Health, the Minister of Health and the First Lady — Formal presentation of the Eight-Year FP Scale-Up Plan, focusing on the gaps in the financing or implementation of activities, in particular priority activities — Advocacy presentation, as was used with the government officials ■ Key donors/stakeholders commit to supporting parts of the scale-up plan	Q4 2013			MCDMCH, organized by Principal FP Officer
		Develop and	■ Create and review FP advocacy strategy at regular meetings of	Q1 2014	■ Number of		FP TWG

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
		implement FP resource allocation advocacy strategy targeting development partners	the TWG — Prior to the TWG Meeting, the FP team at MCDMCH will identify any actions in the Scale-Up Plan that have not received a financing or implementation commitment from the GRZ or another partner — Meet with interested partners to fully present and discuss the plans — Review partners' main interests and match them to potential areas for funding and implementation — Advocate to partners' main concerns — Report back to TWG with any line items still unfunded, and total funding gap expected annually — Discuss further needs with in-country FP2020 partners' group and FP2020 Country Engagement Working Group ■ Develop agenda and messaging for repositioning of FP based on advocacy strategy		documents produced (advocacy strategy)		
SUPERVISION, MONITORING AND COORDINATION (SMC)							
*SMC1. Enhance the governance structure for improved management of FP at every level of the health system *(FP governance structure and program coordinatio*	SMC1.1 Increase capacity and capabilities at central-level FP team	Put in place a central FP lead at the MCDMCH	■ Hire an RH Specialist with clinical experience at MCDMCH to manage the FP and adolescent SRH program, reporting to the Deputy Director of Mother Child Health, including the oversight and implementation of the plan in addition to the current leadership responsibilities — Manage integration of partner and government activities at the national level — Chair the Technical Working Group, and any other primary meetings included in this plan, e.g., the review of curricula — Manage sub-national FP resources as in SMC1.4, including supervision of FP from the central level to the provincial levels, and the supervision process at every other level	Q3 2013	■ Number of resources hired (RH Specialist, 1)	Improved governance and coordination for FP programming	MCDMCH Director MCH
		Hire additional resources	■ Identify specific needs for technical support in FP at the central level (at MCDMCH), obtain approval for these positions, and	Q3 2013	■ Number of resources hired (Chief		MCDMCH Deputy Director MCH

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
n)		needed at the central level for the plan's successful implementation, specifically for program management, outreach, and logistics	hire these resources — 2 family planning officers reporting to the RH Specialist heading the FP/ adolescent SRH unit, e.g., midwives with degrees in nursing □ Chief FP Officer, in charge of scaling up FP activities, in particular for LARCs and the training program □ Principal FP Officer, in charge of CBDs, outreach activities and integration with communities — 1 RH Logistics Coordinator — This is in addition to any partner-seconded resources ■ Solicit partners and MCDMCH for hiring new resources, including seconding individuals		FP Officer, 1; Principal FP Officer, 1; RH Logistics Coordinator, 1)		
		Provide the FP division with necessary ongoing working equipment	■ Procure 4 laptops, for each of the 2 new FP resources, the Deputy Director and the Director ■ Procure 3 printer/ scanner/ photocopiers for the new division, and supply the toner needed ■ Furbish the office for the new resources with desks, chairs and bookshelves ■ Provide the division with a vehicle for management of activities ■ Refurbish or procure new laptops in 2017	Q3 2013; 2017	■ Numbers of equipment procured (laptops, 4; printers, 3; desks, 2; chairs, 4; bookshelves, 4; vehicle, 1)		MCDMCH FP specialist
	SMC1.2 Technical Working Group meetings	Institutionalize FP Technical Working Group Meetings	■ Review Technical Working Group meeting schedule and procedures for calling ad hoc meetings ■ Review TOR for FP TWG and revise as necessary ■ Keep list of TWG members up to date ■ Solicit partner support for hosting MCDMCH meetings and providing tea/coffee ■ Distribute list of monthly Technical Working Group meeting dates annually, including pre-decided discussion topics, such as preparations needed for ICC and Safe Motherhood Working Group meetings, and include in government calendar where appropriate ■ For each meeting, prepare agenda items and ensure a chair; after the meeting, send out the meeting notes, any	Monthly meetings throughout the duration of the plan	■ Number of documents produced (FP Technical Working Group meeting schedule, 1 a year) ■ Number of documents produced (FP Technical		MCDMCH FP specialist

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
			presentations, and information on the next meeting		Working Group membership list, 1) ■ Number of meetings (FP TWG, 1 a month) ■ Number of documents produced (FP Technical Working Group meeting minutes, 1 a month – per meeting)		
		Improve coordination of FP activities with other sectors, particularly for integration with HIV activities	■ A representative from the FP TWG to sit on the HIV TWG and regularly report back to the FP TWG on how members can pursue current and upcoming opportunities for integrated FP/HIV programs and activities, ensuring integrations across activities	Quarterly meetings throughout the duration of the plan	■ Number of meetings attended (HIV TWG)		MCDMCH FP specialist
	SMC1.3 Coordinate with provincial and district-level FP coordinators	Train/orient FP coordinators at the provincial and district level	■ Institute FP coordinators at both the provincial and district-levels, to manage and coordinate FP activities ■ Advocate for Ministry of Finance to include a budget line to make provincial and district –level FP coordinators into a permanent position ■ At the provincial level, orient 1 non-clinical worker from each province who also shares responsibility with another MCH	Q4 2013	■ Number of trainees (provincial FP focal points, orientation, 1 per province) ■ Number of		Coordinated by MCDMCH specialist;

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
			issue, e.g., the individual responsible for adolescent SRH or eMTCT – During a 2 day meeting at the central level, explain the role of FP coordination at provincial level and what is expected of them – Provide training for skills which FP coordinators will need to be trained in, e.g., FP messaging, integration with other services, access points, referral to HCWs □ A separate session is provided on FP supervision in SMC3.1 ■ At the district level, hire a new district-level FP coordinator, also covering another MCH topic (e.g., adolescent SRH or eMTCT) – This resource can be seconded by ongoing partner programs at the district level – The resources will be trained at the provincial level in a 2-day session, *with a follow-up 2-day supervision session in SMC3.1* – Their role will be to spearhead all government FP activities and supervision, and aid in the coordination of local partner activities – They will work with district-level health officers to integrate FP services with other health services, including working with District AIDS Coordinating Advisors (DACAs)		trainees (district FP focal points, orientation, 1 per district)		
		Approve provincial and district-level objectives in the plan	■ Hold a meeting with provincial-level FP coordinators to review, make edits to and approve provincial- and district-level objectives for MCPR, unmet need and teenage pregnancy in the plan ■ Provincial Level FP coordinators hold a meeting with district level focal points in order to disseminate the plan, and approve district level objectives for MCPR, unmet need and teenage pregnancy ■ Review progress on these objectives and revise as needed as part of regular national review meetings, upon the release of the	Q2 2014; Q2 2017	■ Number of meetings (provincial FP coordinator objective review, 1 a year)		Provincial- and district-level FP coordinators

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
			DHS and at the mid-term plan review				
		Distribute copies of the 8 year FP scale-up plan and executive summary brochure to officials at national, provincial and district levels	■ Print and distribute copies of the plan — FP team at MCDMCH, provincial and district-level FP coordinators — Relevant government institutions, e.g., MOH, MSL and MOESVTEE — Partners, including those not yet involved in FP as part of the advocacy strategy ■ Print and distribute copies of the executive summary brochure — Those listed above, plus all service delivery points	Q3 2013	■ Number of documents disseminated (FP plan; executive summary brochure)		MCDMCH
SMC2. Develop supervision tools, including data collection tools and a dashboard	SMC2.1 Review HMIS indicators on FP	Define indicators to be tracked as part of plan implementation in the executive dashboard	■ Develop list of indicators to be tracked — Included in HMIS, and where appropriate, Smartcare — Not included through HMIS, but tracked at health centres and health posts, such as stock levels, new users by method, and trained providers — *Short-list output and outcome indicators in this plan for priority elements* ■ Revise indicators as part of mid-term plan review in 2017	Q3 2013; Q2 2017	■ Number of documents produced (list of HMIS indicators to track, 1)	Improved FP data reporting, including partners FP service numbers ■ Facilities, districts and provinces reporting (supervisory reports)	TST; 2017 review by MCDMCH FP specialist
		Review the existing M&E data collection tools and make recommendations	■ Review current M&E collection tools used in health care facilities to track user data, which is then entered into the HMIS — Includes forms that are filled out by CBDs or CBD reports at the health centres — Take into account any system changes, such as the possible rollout of DHIS2 ■ Propose changes to the tools and bring these to the FP TWG for approval ■ Review these again as part of the mid-term plan review	Q4 2013; Q2 2017	■ Number of documents produced (M&E collection tools, 1)		MCDMCH FP specialist

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
		Standardize information needed from partners to track overall FP progress	■ Determine service data desired from partners to track FP progress ■ Ask partners to report these quarterly at FP TWG meetings in the dashboard, and to provide more detailed data as part of the mid-term plan review	Q1 2014	■ Number of documents produced (partner update template, 1)		MCDMCH FP specialist
		Pilot mobile - technology to track contraceptive stocks at Health facility level (SMS applications)	■ Develop pilot to track stocks at the health centre level, including FP commodities ■ Integrate with DHIS2 if it is rolled out ■ Review progress and plan for scale-up as part of mid-term plan review	2016	■ Number of documents produced (report on M-Track digital technology pilot, 1)		MCDMCH RH Logistics Coordinator and MSL
	SMC2.2 Review and strengthen the supervision tools for family planning	Review current supervision tools	■ Review current supervision tools to ensure all output indicators of the plan are effectively tracked ■ Approve new tools in FP TWG	Q3 2013	■ Number of documents produced (supervision tools, 1) ■ Percentage of facilities using the new supervisory tools		MCDMCH FP specialist
		Disseminate revised supervision tools to the provincial and district levels	■ Memo from the PS introducing the new supervision tools and explaining the frequency at which they should be completed	Q1 2014			MCDMCH Chief FP officer with support from MCDMCH FP specialist
	SMC2.3 Develop executive dashboard to monitor implementation of the 8 FP Scale-up plan	Development of Executive Dashboard	■ Develop simple, easy-to-read dashboard for tracking progress in FP, based on outcome indicators in this plan — Ensure necessary data is trackable or already tracked through HMIS, Smart or the DHS — Track progress, process, and financing indicators	Q3 2013	■ Number of documents produced (executive monitoring dashboard, 1)		TST
		Update and review the executive	■ MCDMCH updates dashboard quarterly based on input from provincial FP coordinators ■ Dashboard is reviewed quarterly as part of regular TWG	Ongoing at FP TWG	■ Number of updates (executive		MCDMCH FP specialist

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
		dashboard regularly	meetings, and at annual national review meetings	meetings, on a quarterly basis	dashboard, 1 a quarter)		
SMC3. Conduct supervisory visits of FP activities	SMC3.1 Training supervisors in FP supervision	Train provincial and district-level FP coordinators in coordination supervision	■ Train new FP coordinators in supervision of FP activities, in a 2-day follow-up session to the initial orientation sessions	Q4 2013, continuation of coordinator orientation session	■ Number of trainees (provincial and district-level FP focal points, FP supervision, 1 per province and 1 per district)	Improved supervision of FP activities at every level	MCDMCH FP Specialist
		Train health facility level supervisors in FP supervision	■ Train FP supervisors from the health facilities — Train 300 supervisors a year, in 5-day sessions of 30 participants at each province	Q3 2014; Q1 2015; Q1 2016	■ Number of trainees (heatl facility supervisors, FP supervision, 300 a year)		
	SMC3.2 Supervision and quality assurance of FP activities	Supervise annually from central level to provinces	■ Annual quality assurance and supportive visits to provincial health officers done by the MCDMCH supervisors at the central level	Annually in Q3	■ Number of supervisory visits conducted (to provinces, annually)		MCDMCH Chief FP Officer
		Supervise semi-annually from provincial level to districts	■ Semi-annual quality assurance and supportive visits to district health offices done by the provincial-level FP coordinators	Semi-annually in Q1 and Q3	■ Number of supervisory visits conducted (to districts, semi-annually)		Provincial-level FP coordina

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
		Supervise quarterly from districts to health centres and health posts	■ Quarterly quality assurance and supportive supervision visits to FP service points including CBD programs, done by the district-level FP coordinators	Quarterly	■ Number of supervisory visits conducted (to health centres and health posts, quarterly) ■ Percentage of health centres and health posts supervised (at least every 6 months)		District-level FP coordinators
		Supervise monthly from the health centres to CBDs	■ Monthly quality assurance and supportive supervision visits to CBDs providing FP commodities, done by health centre staff ■ Done at the same time as CBD data is collected and commodities replenished	Monthly	■ Number of supervisory visits conducted (to CBDs, monthly) ■ Percentage of CBDs supervised (at least quarterly)		Health centre in charges
SMC4. Regularly review plan progress and scale-up successes	SMC4.1Conduct mid-term review of plan	Review progress of plan	■ Review initial situational analysis, DHS 2014 data and latest HMIS indicators ■ Review progress of plan against the objective of 58% MCPR in 2020; revise this objective if necessary ■ Conduct assessment of progress of adolescent FP/SRH using the WHO strategic approach, to determine the progress since the institution of the new curriculum in 2014 – Develop assessment tool and study methodology – Review SRH policies and programs in selected	Q2 2017	■ Number of documents produced (situational analysis, 1; review of plan progress, 1; adolescent SRH		MCDMCH FP team and FP TWG

Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
			schools/colleges, universities and their administrative structure using assessment tool (the focus should be on assessing issues for adolescent knowledge and access to FP services, not on the curriculum as a new curriculum is being implemented in 2014) – Review SRH policies and programs in selected youth associations using assessment tool ■ Interview adolescents, youth, teachers, parents and other influential figures from schools/colleges, to determine issues in perception and use of FP amongst adolescents and youth (around demand creation, sources of information and accessibility of FP services)Discuss modifications needed to the plan's activities, including key topics such as LARCs and adolescents. Convene a special day-long meeting of the FP TWG to discuss the progress, recommendations, and approve any changes		assessment, 1; updated implementation plan, 1) ■ Inclusion in FP TWG agenda (mid-term plan review)		
	SMC4.2 Review DHS results to determine progress	Update objectives or revise activities as needed based on DHS data	■ Update progress on plan and revise any major changes to objectives and activities based on DHS data	Q2 2014; 2019	■ Number of documents produced (updated objectives, 1; updated implementation plan if needed, 1)	Frequent review of FP activities and plan progress	FP TWG
	SMC4.3 Conduct review meetings regularly to supervise the plan's implementation and review best	Hold semi-annual review meetings to revise progress on FP plan at central level	■ One-day meeting of MCDMCH with provincial-level FP coordinators ■ Review of progress on activities using simplified roadmap ■ Review of progress on FP2020 commitments ■ Share best practices ■ Review analysis of data available from provinces and readjust activities as needed	Semi-annually in Q1 and Q3	■ Number of meetings (national FP review, 2 a year)		MCDMCH MCH Deputy Director with support from full FP team
		Hold semi-annual	■ Two-hour meeting of provincial-level FP coordinators with district-level coordinators and key partners	Quarterly	■ Number of meetings		Provincial-level FP coordinators

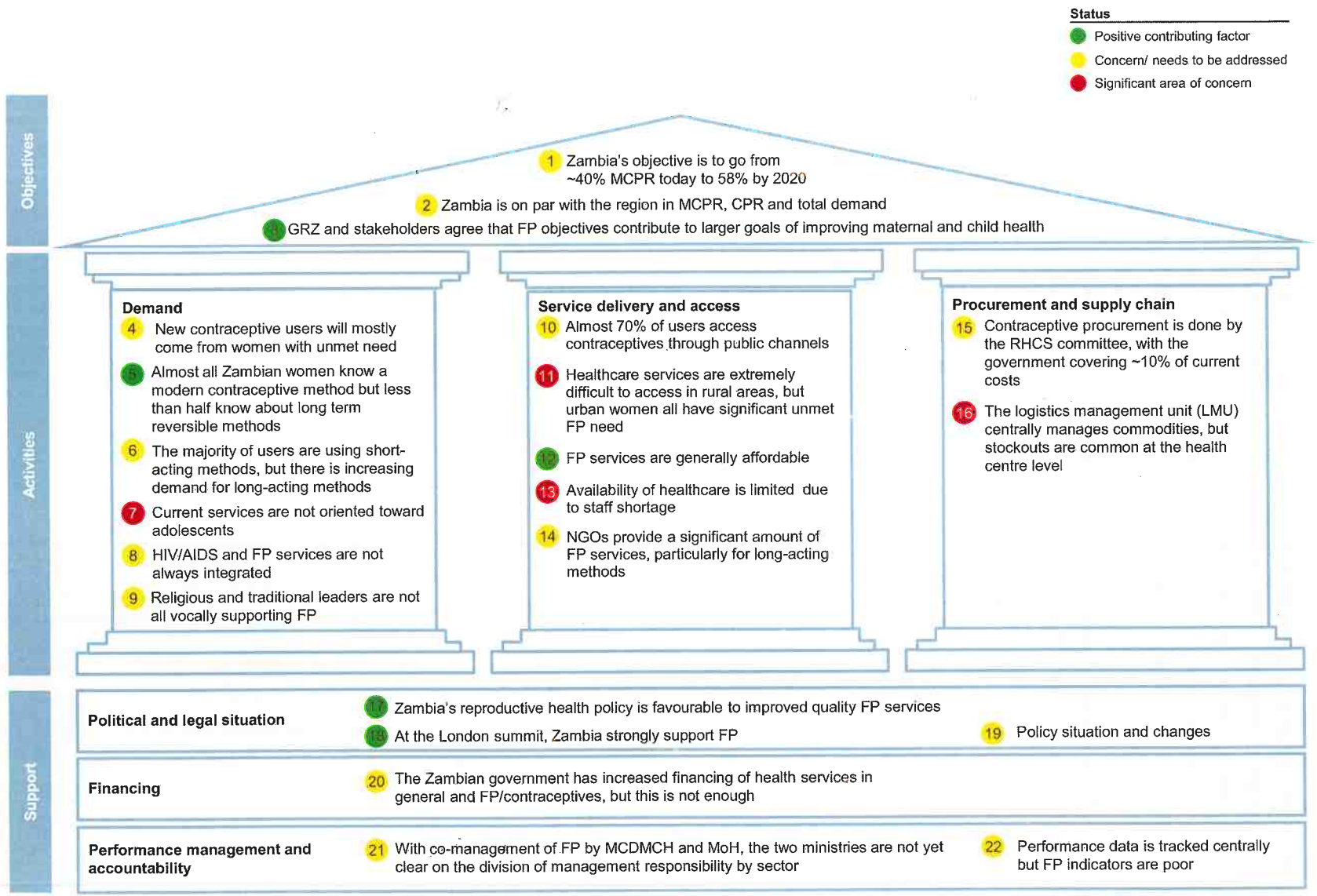
Activity *Priority activities	Sub-activity	Sub-activity elements	Additional Detail	Time Frame	Output Indicators (quantity)	Outcome Indicators (means of verification)	Responsible
	practices	review meetings to revise progress on FP plan at provincial level	■ Review partner activities and ensure these are well-coordinated ■ Follow-up with progress on activities and any key issues in implementation ■ Share best practices ■ Review analysis of data available from districts		(provincial FP review, 4 a year per province)		
		Hold semi-annual review meetings to revise progress on FP plan at district level	■ Two-hour meeting of district-level FP coordinators with district-level officials, key partners, and provincial-level FP coordinators ■ Follow-up with progress on activities and any key issues in implementation ■ Share best practices ■ Review analysis of data available from health centres ■ Ensure all facilities are reporting	Quarterly	■ Number of meetings (district FP review, 4 a year per district)		Provincial-level FP coordinators

Annex C: Zambia family planning landscape

As part of the process to detail and cost this plan, a comprehensive Zambian family planning landscape was developed. The landscape includes a FP situation landscape, a partner landscape, and a landscape of the elements of the preliminary plan. This document is available in full electronically from MCDMCH and can be used as a reference in programming FP activities. It was used as one of the inputs to determining the strategic priorities of the plan.

Find below the framework used in Section 1: Introduction to review the Zambian context, and the summary of Zambia's FP situation.

Chart 6: Summary of Zambia's FP situation



Annex D: Family Planning Technical Working Group Members

S/No	ORGANISATION	POSITION
1	Ministry of Community Development Mother and Child Health (MCDMCH)	Director Maternal Child Health *(CHAIR)*
2		Deputy Director MCH
3		Chief Safe Motherhood Officer
4		RH Specialist (new)
5		Adolescent Reproductive Health Specialist
6		Chief FP Officer (new)
7		Principal FP Officer (new)
8		Family Planning Specialist
9		RH Logistics Coordinator
10	Ministry of Health (MOH)	Family Planning Officer
11		RHCS Coordinator
12	University Teaching Hospital (UTH), MOH	Consultant Obstetrician Gynaecologist
13	MOH Results Based Financing (RBF)	Senior RH Specialist
14	Churches Health Association of Zambia (CHAZ)	Deputy Director, Health Programmes
15	United Nations Population Fund (UNFPA)	Reproductive Health Programme Manager
16		Midwifery Program Officer
17		SRH-HIV Linkages Coordinator
18		Fistula Coordinator
19	UNICEF	Maternal and Newborn Health Specialist
20	World Health Organization (WHO)	Program Manager
21	United States Agency for International Development (USAID)	FP and MNCH Advisor
22		Program Manager
23	USAID | DELIVER Project (John Snow Inc./ JSI)	Public Health Logistics Officer
24		Public Health Logistics Advisor
25	DfID	Health Advisor
26	Bill & Melinda Gates Foundation (BMGF)	Senior Advisor Africa & Global Health
27	Planned Parenthood Association of Zambia (PPAZ)	Executive Director
28		Logistics Officer
29		Programs Manager, Clinical Services
30	Family Health International (FHI360)	Program Officer/ CBD Coordinator
31		Technical Director
32		Consultant
33	Marie Stopes International (MSI)	Clinical Services Director
34		Operations Director
35	ChildFund	Technical Advisor on Health
36	Society for Family Health (SFH)	RH Program Manager

S/No	ORGANISATION	POSITION
37		Health Services Director
38	Scaling Up Family Planning (SUFP)	Country Program Director
39		Program Manager
40	Zambia Integrated Services Strengthening Program (ZISSP)	MNCH Team leader
41		Deputy Chief of Party
42		Capacity Building Specialist
43	Communications Support for Health (CSH)	Program Manager
44	JHPIEGO/ MCHIP	Project Manager
45		Country Director
46	PATH	Program Officer
47	Youth Vision Zambia	Executive Director
48	Clinton Health Access Initiative (CHAI)	FP Program Manager
49	Maternal Health Association of Zambia (MHAZ)	Executive Director
50	Plan International	Health Manager
51	MSD/Merck	Key Account Manager
52	BU/ ZCAHRD	Project Director
53	General Nursing Council of Zambia (GNCZ)	Training and Education Manager
54	*Health Professionals Council of Zambia (HPCZ)*	*TBD*
55	*Medical Stores Limited (MSL)*	*TBD*

Annex E: Preliminary Yearly Objectives

In order to facilitate the monitoring of the plan's success, the national specific objectives can be translated to yearly objectives. This is a tool to help track the plan's progress on a yearly basis, as data is collected and analysed. These yearly objectives have been provided for the specific objectives of MCPR, unmet need and teenage pregnancy laid out in the plan. Furthermore, the MCPR objectives have tentatively been translated to the provincial level, to allow provincial leaders to determine how their province's progress contributes to Zambia's overall progress towards the 58% national MCPR objective by 2020.

Based on the input assumptions used developed for use in the costing and impact calculations, a 2012 baseline for contraceptive use was established, with a split to estimate the MCPR in each province. The 2007 DHS was used as a baseline for 2012 in both the unmet need and teenage pregnancy calculations, as no reliable estimate could be developed from existing data. These yearly objectives should only be considered tentative, as they still need to be approved, in particular at the provincial level. Consensus building will need to be conducted at the level of the provinces to ensure buy-in and commitment to these aspirational objectives.

All objectives should be revised once the latest DHS data is released in 2014, and again in 2019. In particular, it will be valuable to have data for Muchinga province, which did not yet exist when the last DHS was conducted in 2007.

Objectives for MCPR

To calculate MCPR objectives, the potential for growth was considered at the level of each province, in both demand and access. Factors in demand potential include MCPR, unmet need, teenage pregnancy and TFR; and in access potential include population density and WRA per health facility. A province with low MCPR, high unmet need, high teenage pregnancy and high TFR was considered to have high demand potential. A province with high population density and low WRA per health facility was considered to have high access potential.

Using this ranking, provinces were subjectively sorted into 5 categories:

- Very high potential for growth: Luapula
- High potential for growth: Muchinga
- Medium potential for growth: North Western, Western, Southern, Central, and Northern
- Low potential for growth: Copperbelt and Lusaka (mainly due to existing high access to health facilities)
- Very low potential for growth: Eastern (mainly due to very high existing MCPR)

The overall annual growth rate needed for Zambia to go from 38.1% (married) MCPR in 2012, to 58% (married) MCPR in 2020, is 2.5% a year. For each province in the ranking, annual growth rates were suggested that would lead to an overall 2.5% growth for Zambia. The annual increase rates (Table 7) have been further scaled by year on an S-curve; as it is assumed that uptake will be slower at first, and speed up as the plan is further implemented.

These provincial objectives are then aggregated at the national level to provide overall yearly objectives for Zambia (Table 8). Married MCPR objectives have also been translated into approximate all WRA MCPR objectives, as these were needed to calculate the overall contraceptive needs.

Table 10: Suggested provincial objectives for annual married MCPR increase in Zambia, by province, on average

North Western	Medium	2.8%
Western	Medium	2.8%
Southern	Medium	2.8%
Central	Medium	2.8%
Copperbelt	Low	2.3%
Lusaka	Low	2.3%
Luapula	Very high	3.5%
Northern	Medium	2.8%
Muchinga	High	3.3%
Eastern	Very low	1.8%
TOTAL		**2.5%**

Table 11: Objectives for married MCPR in Zambia, by province and by year

Province	2012	2013	2014	2015	2016	2017	2018	2019	2020
North Western	26.1%	28.2%	30.5%	33.1%	35.9%	38.8%	41.8%	44.8%	48.1%
Western	26.8%	28.9%	31.2%	33.8%	36.6%	39.5%	42.5%	45.5%	48.8%
Southern	45.6%	47.6%	50.0%	52.6%	55.3%	58.2%	61.2%	64.3%	67.6%
Central	31.7%	33.8%	36.1%	38.7%	41.5%	44.3%	47.4%	50.4%	53.7%
Copperbelt	48.4%	50.1%	52.0%	54.1%	56.4%	58.7%	61.2%	63.7%	66.4%
Lusaka	46.4%	48.1%	50.0%	52.1%	54.4%	56.7%	59.2%	61.7%	64.4%
Luapula	16.3%	18.9%	21.9%	25.2%	28.7%	32.4%	36.3%	40.1%	44.3%
Northern	19.7%	21.8%	24.1%	26.7%	29.5%	32.3%	35.4%	38.4%	41.7%
Muchinga	19.7%	22.1%	24.9%	28.0%	31.2%	34.6%	38.2%	41.8%	45.7%
Eastern	56.5%	57.8%	59.3%	61.0%	62.7%	64.6%	66.5%	68.4%	70.5%
TOTAL	38.1%	**40.1%**	**42.2%**	**44.6%**	**47.1%**	**49.7%**	**52.4%**	**55.2%**	**58.2%** *(58% objective)*

Table 12: Objective for MCPR for all WRA in Zambia, by year

	2012	2013	2014	2015	2016	2017	2018	2019	2020
Yearly objectives	28.5%	30.2%	32.0%	33.8%	35.6%	37.3%	39.1%	40.9%	42.7%

Objectives for unmet need and teenage pregnancy

Unlike for MCPR, the data currently available for unmet need, teenage pregnancy and related indicators is insufficient to give a reliable split at the provincial level. For this reason, only national-level yearly objectives have tentatively been provided. A new baseline for 2012 was not calculated either due to these restrictions.

Similarly to MCPR, the necessary yearly increase for both unmet need and teenage pregnancy was first calculated, and then scaled on an S-curve assuming higher uptake of contraceptives, and so a lower unmet need and teenage pregnancy, later on. Both of these took into consideration the existing yearly objectives set forth in the MNCH roadmap, to reach 14% unmet need by 2015, and 18% teenage pregnancy by 2015; but on a timescale to 2020. The progress and objectives will need to be adjusted once the 2014 DHS results are released.

Table 13: Objective for unmet need in Zambia, by year

	2012	2013	2014	2015	2016	2017	2018	2019	2020
Yearly objectives	26.6%	**25.3%**	**24.1%**	**22.8%** *(19% objective)*	**21.6%**	**20.1%**	**18.3%**	**16.3%**	**14.1%** *(14% objective)*

Table 14: Objective for teenage pregnancy in Zambia, by year

	2012	2013	2014	2015	2016	2017	2018	2019	2020
Yearly objectives	27.9%	**27.0%**	**25.9%**	**24.7%**	**23.5%**	**22.2%**	**20.8%**	**19.5%**	**18.0%** *(18% objective)*

Addendum on Long-Acting Reversible Contraceptives (LARC)

Introduction

Long-acting reversible contraception (LARC) – implants and intrauterine devices – is critical to the health of women and children in Zambia and the continued economic development of the country. As part of the country's overall goal to reduce the maternal mortality ratio from 591 to 162 deaths per 100,000 live births, Zambia has made commitments to increase the rate of use of modern family planning (FP) methods in the country from 32.7% to 58% by 2020 and to reduce unmet need for contraception from 27% to 14% by 2020.[38] Use of LARC, which is more effective and longer-acting than other non-permanent methods of contraception, will be particularly important in helping Zambia to reach these goals.

In August 2013, Zambia's Eight-Year Integrated FP Scale-Up Plan, 2013-2020 was finalized by the Ministry of Community Development, Mother and Child Health (MCDMCH). The Eight-Year Plan lays out strategic priorities and specific activities required to achieve Zambia's family planning goals for contraceptive prevalence rate (CPR) and unmet need, including significant efforts to expand access to and uptake of LARC. This document is an addendum to the Eight-Year Plan. Its purpose is to highlight the LARC activities described in the Eight-Year Plan and provide a quick reference for the MCDMCH and partners on the LARC components of the Eight-Year Plan.

The Need for Long-Acting Reversible Contraception in Zambia

Following principles of equity, all women should have access to the widest possible array of choices for voluntary family planning. LARC is the most effective type of FP (see Table 15) and one of the most convenient, requiring only a single contact with a health care provider every few years and no other actions on the part of the user. Because an implant can be used for three to five years and an IUD for up to ten years, but

Table 15: Use and Efficacy of Family Planning Methods in Zambia*

Method	Percent Using[39]**	Efficacy of Method***
Pill	33.5%	91.00%
Injectable	25.9%	94.00%
LAM[2]	18.9%	98.00%
Male Condom	14.3%	82.00%
Female Sterilisation	5.8%	99.50%
Implant	1.2%	99.95%
IUD	0.3%	99.20%
Total	100%	

*Efficacy = % of women who, with typical use of the method, do not experience an unintended pregnancy within the first year of use. Efficacy for LAM (lactational amenorrhea) is given for perfect use (not typical use) and is given for a 6-month period (rather than 1 year), because LAM can be used for a maximum of 6 months.

**DHS2007 p. 74.

*** Source: Trussel, J: "Contraceptive failure in the United States," *Contraception* 83:397-404:2011.

38 Eight-Year Integrated FP Scale-Up Plan, 2013-2020.

39 Zambia Demographic and Health Survey, 2007

can be removed at any time, these methods are ideal both for women who want to space or delay pregnancy and for those who want no more children.

In Zambia, 40% of urban married women and 42.9% of rural married women have a desire to space childbearing by two or more years, and 31.6% of urban married women and 21.9% of rural married women have a desire to limit childbearing,[40] indicating a significant desire for FP methods such as LARC. However, unmet need for FP of all types remains very high in Zambia: 23.2% and 28.2% for urban and rural married women respectively.[41]

Despite the effectiveness and convenience of LARC and the significant demand in Zambia for FP that supports child spacing and child limiting, LARC has remained largely underutilized compared with short-acting FP methods (see Table 1). Zambian women have demonstrated demand for LARC – particularly implants – during the past few years, when it has increasingly been offered by non-governmental organizations (NGOs): average monthly consumption grew from about 2,500 in the first half of 2012 to about 5,000 enduring the first half of 2013. However, continuing high unmet need for FP and low overall usage of LARC suggest that to date, implants and IUDs have not been sufficiently accessible to women in Zambia.

Current Status of LARC in Zambia

In the Government of the Republic of Zambia (GRZ) structure, FP activities fall under the jurisdiction of the Ministry of Community Development, Mother and Child Health (MCDMCH). Health care is provided within government and mission-owned facilities, including approximately 250 health posts (HPs), 1,000 rural health centers (RHCs), 200 urban health centers (UHCs), 71 Level 1/District Hospitals, 16 Level 2 Hospitals and six Level 3 Hospitals. FP services are available at almost all facilities, with the exception of those run by religious orders which do not support FP, and HPs, which have very limited clinical services. In most facilities, the only FP methods included during routine services are condoms, pills and injectables; LARC is provided at some GRZ facilities, most often by NGO staff working via outreach. Supply data from a subset of districts indicates that 34% of facilities requested implants and 4% requested IUDs from the central store during January 2013, indicating that a minority of facilities are providing these services.[42] There are several reasons why LARC is currently underutilized in Zambia, including limited knowledge, accessibility and availability.

Knowledge of LARC

In 2007, of Zambian women, 92.2% were familiar with condoms, 91.5% with pills, 86.8% with injectables, but only 43.3% with implants and 35.8% with IUDs.[43] In addition, representatives of the MCDMCH and of NGOs in Zambia report that various negative myths and false beliefs about LARC exist in communities in Zambia: for example, that implants and IUDs can travel around the body, becoming lodged in the brain, the heart or a growing fetus; and that fertility will not return after LARC removal. Some Zambian health care providers also have negative

40 Zambia Demographic and Health Survey, 2007, p108.

41 Zambia Demographic and Health Survey, 2007, p108.

42Personal communication from John Snow, Inc. staff, June 18, 2013. The subset of districts are those 27 districts participating in the Essential Medicines Logistics Improvement Programme (EMLIP).

43 Zambia Demographic and Health Survey, 2007, p.68. Data shown is for currently married women of reproductive age.

beliefs about IUDs in particular: that they cannot be used in nulliparous women and that they frequently cause infection.

Accessibility of LARC

In order for LARC to be accessible to women, it must be provided at an affordable cost, at a location reasonably close to home, and at a convenient time.

In Zambia, direct cost is not a barrier to access of FP. All FP is free at GRZ facilities and NGO outreach sites and is provided at low or no cost at NGO fixed sites.

Distance to a health facility is generally not an access barrier for the 39% of Zambian women who live in urban areas, where average travel time to a HC is less than 20 minutes. Distance is often an access barrier for rural women, whose average travel time to a HC is two hours and often longer in the rainy season.[44] However, the facts that 91.2% of rural women receive antenatal care[45] and 91.3%[46] of rural children receive at least one vaccination dose by the time they reach 12 months of age suggest that women can surmount the inconvenience of relatively lengthy travel to access health services that they value.[47]

Routine FP services at GRZ and mission health care facilities are usually provided for very limited hours (e.g., a few hours on a single day each week). Also, the schedule for routine FP services is generally not coordinated with the provision of other popular services that women attend (e.g., under 5/immunization clinics). Therefore the scheduling of services can be a barrier to access for women, as they may not be able to present at the clinic during the limited hours and may have difficulty traveling repeatedly to the clinic for different services provided on different days. On the occasions when NGOs provide LARC and other FP methods, scheduling barriers are reduced, as the NGO's FP clinic lasts most of the day and an attempt is made to schedule this clinic on the same day as under 5/immunization clinics.

Availability of LARC

LARC is provided as a routine FP service in most large hospitals in Zambia, however, as mentioned above, it is seldom provided as a routine service in GRZ FP clinics in HCs and other hospitals. The major reason for this is shortage of clinical staff, which is severe in the Zambian health sector (see Table 2: Staffing situation from 2005 to 2009), and most severe in rural areas. Staff shortage is associated with conflicting priorities and excessive workload for existing staff, resulting in inability to perform non-urgent and relatively time-consuming tasks such as providing LARC, even when a health care worker (HCW) who has been trained in LARC is present. While a comprehensive map of LARC availability in Zambia does not exist, Table 18: LARC-related activities by Province, District and NGO indicates the districts in Zambia where GRZ staff have been trained in LARC and where several NGOs provide LARC services.

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44 Hjortsberg CA, Mwikisa CN: "Cost of access to health services in Zambia," Health Policy and Planning; 17(1):71-77, 2002.

45 Zambia Demographic and Health Survey, 2007, p.124.

46 Zambia Demographic and Health Survey, 2007, p.142.

47 Zambia Demographic and Health Survey, 2007.

At many sites, there is no GRZ HCW who has been trained in LARC skills. In order to increase the provision of LARC as a component of routine FP services, several hundred GRZ HCWs have received in-service LARC training during the past few years. However, this has not had a significant impact on the LARC services provided by the public sector as evidenced by the fact that NGOs continue to account for over 80% of implants and IUDs provided. Formal trainings have been conducted by both GRZ and NGO trainers as part of their outreach 'dedicated FP provider' (DFPP) programs and as part of regional FP trainings. A few have been part of an MCDMCH initiative to integrate FP with other health care services, such as HIV and postpartum care. MCDMCH and NGO representatives report that some HCWs who have completed in-service training are competent to provide LARC at their workplace but that others are not, largely because they have not had sufficient practical experience to be confident in their skills. As a further complication, the standard GRZ LARC training program is expensive, because it involves approximately two weeks of off-site formal training for each group of trainees; in 2014, decentralization of training to the Provinces through the Eight-Year Plan may reduce training expense somewhat. In addition, LARC will be more fully integrated into the pre-service curriculum for midwives (and possibly nurses) during the next few years through the Eight-Year Plan.

The physical infrastructure of health care facilities in Zambia is generally adequate for LARC; most have a private clean area where a woman can lie down – a requirement for LARC counseling and insertion. However, LARC services require equipment (specific surgical instruments and sterilisation capability), commodities (the implant or IUD) and consumables (for skin cleaning, anaesthesia and bandaging). Not all health care facilities have the equipment required on site. Stock outs of commodities and consumables are fairly common, particularly at the HC level. Data from a subset of districts indicate that of facilities managing implants, 27% experienced a stock out in January 2013.[49] Causes cited for stock-outs include inadequate transport to transfer supplies from the district storage area to the HC and, to a lesser extent, incorrect forecasting for and ordering of supplies at the facility level and, occasionally, shortages at the national level. GRZ is working to resolve these supply problems, through decentralization of warehousing and distribution and through direct ordering by HCs, changes that are projected to be completed in 2015.

Table 16: Number and Percent of Established Health Posts Filled, Zambia 2009

Staff Category	Number Employed[48]	Approved Establishment	Percent of Establishment Employed
Doctors	801	2,300	35%
Clinical Officers	1,376	4,000	34%
Midwives	2,374	5,600	42%
Nurses	7,123	16,732	43%

48 National Health Strategic Plan 2011-2015, p. 22 (data are from 2009)

49 Personal communication from John Snow, Inc. staff, June 18, 2013. The subset of districts are those 27 districts participating in the Essential Medicines Logistics Improvement Programme (EMLIP).

As described above, a minority of LARC services are provided by GRZ staff. However, LARC, along with other FP methods, is provided in the majority of the districts in Zambia by DFPPs employed by NGOs (see Appendix 1). The DFPPs work at approximately 20 fixed NGO-managed sites and 600 GRZ and mission-run outreach sites, where NGO staff holds DFPP clinics on a regular basis – weekly, monthly or quarterly. NGOs currently provide approximately 80% of the LARC in Zambia, predominantly through this model, and have succeeded in rapidly expanding access to LARC for some Zambian women. Factors which have contributed to the success of these programs include: minimizing clinical staff needs by using a relatively small number of staff to cover many locations; avoiding problems of conflicting clinical priorities by using dedicated FP staff; increasing convenience for women by scheduling DFPP clinics on the same days as under 5/immunization clinics; conducting the DFPP clinics at urban, peri-urban and rural locations that are close to where women live; and avoiding service interruptions caused by local stock outs by supplying the equipment, commodities and consumables required.

Strategies for Scale-up of LARC in Zambia

To scale-up LARC in Zambia, the following are recommended in the Eight-Year Integrated FP Scale-Up Plan, and described in more detail here and in the attached activities table. The corresponding section of the Eight-Year Integrated FP Scale-Up Plan is noted in parentheses following each recommendation.

1. **Increase knowledge of LARC by raising public awareness and educating providers. (D1, D2)**

In order to increase knowledge about LARC, education of all levels of health care workers – from community based distributors (CBDs) to doctors – should be reviewed and revised to include familiarity with LARC, including its benefits and risks. This should include clinical and nonclinical health staff who may not be directly providing insertion and removal services so that, at a minimum, appropriate counselling and referrals for LARC can be made at all levels. Familiarity with LARC should be included in: 1) pre-service education for doctors, clinical officers, midwives, nurses and CHAs, 2) routine informational sessions or informational literature provided to all health care providers working in GRZ and mission-run facilities, and 3) the standard training package for CBDs.

Any public education regarding FP – including posters in health facilities, education through the media and community events – should include information about LARC, focused on its benefits and risks, on its efficacy compared with other FP methods and on dispelling common myths and false beliefs.

2. **Increase availability of LARC by strengthening pre-service clinical training of providers (SDA5)**

In order to increase availability of LARC, pre-service, competency-based clinical training on provision of LARC counselling, insertions and removals should be included in the education of doctors, clinical officers, midwives and nurses. Each trainee must practice LARC skills on models and, under supervision, perform LARC insertion and removal on multiple women until competency is established. To accomplish this, the MCDMCH will work with the General Nursing Council (GNC) to ensure that all nursing and midwifery schools have a sufficient number of arm and pelvic models and that clinical placements include robust practical training in LARC. In some cases, this may entail utilizing DFPP sites for practical training in order to ensure adequate patient experience with LARC.

3. **Increase availability of LARC by providing cost-effective in-service clinical training to a subset of strategically selected providers (SDA2 – 4)**

LARC in-service clinical training of GRZ employees should focus on staff who work in settings where it will be realistically possible, under current staffing constraints, to provide LARC as part of routine FP services. Hence, priority should be given to providing full clinical LARC training to employees of hospitals and large, well-staffed HCs. An in-service training plan will be developed to effectively target training, harnessing government and partner resources, in a single harmonized national training plan. The plan will be designed to provide high-impact training at relatively low cost. Decentralized training at the district or facility level can be less expensive than centralized training. Training which occurs at the trainees' own work-sites has often been demonstrated to be more effective than off-site training, particularly because it allows trainers and trainees to identify and mitigate local barriers to successful implementation of new activities[50]. Each LARC trainee generally must complete a minimum of 10 – 15 actual implant and IUD insertions and several implant and IUD removals to attain competence. Therefore, class size for practical training must be small; it is otherwise nearly impossible to mobilize a sufficient number of patients for adequate practice.

50 Jhpiego Corporation: "Effective In-Service Training Techniques, Timing, Setting and Media: Evidence from an Integrated Review of the Literature". P. 51 2012. AND Jhpeigo Corporation: "On-Site Training at Public Hospitals in Ethiopia (Draft)". P. 2 April, 2007

4. Increase availability of LARC by modifying the service delivery model for LARC. (SDA1, SDA6)

In all GRZ RHCs, UHCs and hospitals and in those mission-run facilities that support FP, LARC services should be organized to optimize service delivery under the severe staffing constraints these facilities face.

LARC should continue to be provided as part of routine FP services at large hospitals in Zambia. However, the structure, staffing and scheduling of these services should be reviewed to ensure that demand for LARC is being met. Possible strategies for reorganizing services to provide LARC include having a single nurse or midwife exclusively provide LARC during routine FP clinics, while other staff provide short-term methods; or providing group FP education and counselling to optimize use of staff time. If it is not possible for a hospital to prioritize LARC during routine FP clinics, general counselling regarding LARC must be provided during these sessions, but detailed counselling and LARC insertion and removal could be limited to regularly scheduled and advertised 'LARC Days'. During such LARC Days, staff can focus their attention on providing LARC for women who choose it.

In all facilities where LARC is not currently provided as part of routine FP service, LARC should be provided through an expanded program of DFPPs, led by the GRZ. The goal of this program will be to increase access to LARC at lower level facilities very rapidly, until the number of Zambia's health providers is sufficient and routine FP services, including LARC, can be provided regularly and dependably. Even as DFPPs are deployed, local GRZ HCWs will remain responsible for providing FP services on demand to the existing catchment population. However, routine visits from DFPPs will relieve the burden on these HCWs while also ensuring LARC services are regularly available to clients. In addition to providing FP services, DFPPs will provide the practical portion of LARC training to local HCWs who have received formal training in LARC, ensuring their competence. Once competent in LARC, local HCWs will be equipped to provide LARC on demand to some clients as part of routine FP clinics. As staffing levels at facilities improve, it may be possible for local HCWs to assume responsibility for all LARC services at their sites.

Essential characteristics of this DFPP model include:

- GRZ will coordinate all DFPP outreach services, leveraging existing NGO resources and expanding application of the DFPP model through use of GRZ-employed full-time DFPP outreach teams
- DFPP teams composed of one or two nurses or midwives who are competent in LARC plus one driver/assistant will be established in each district as necessary. In many small districts, a single DFPP team or a team shared with another district will be sufficient to meet demand (e.g., via monthly DFPP clinics at various sites). In larger, more populous or urban districts, more than one DFPP team will be required to meet demand (e.g., to provide weekly DFPP clinics at various sites). A vehicle is required for each DFPP team. For purposes of clinical supervision, a district's DFPP teams should be based at a hospital in the district or at the district medical office. DFPP teams will report to the District FP Coordinator.
- All services provided by DFPP will occur at, or in close proximity to, GRZ and mission-run UHCs and RHCs. This is essential both because most Zambians rely on their local facilities for health care and this relationship should not be disrupted and because

LARC clients should identify their local facility as the source of follow-up care for LARC, including for complications, side-effects and removal.

- DFPP clinics should be conducted on the same day as under 5/immunization clinics, particularly in rural areas.
- Community mobilization and advertising for DFPP clinics should be provided via signs and posters at the health care facilities and by the CBDs, Safe Motherhood Action Groups (SMAGs) and local health committees prior to the DFPP clinic.
- Equipment, commodities and consumables for DFPP outreach should be supplied by the DFPPs; however, local HCWs should be trained to order needed supplies and should continue to manage their own FP inventory, as they will remain responsible for providing FP services on non-outreach days.
- Training in management of common LARC complications and side-effects should be provided in formalized on-the-job in-service training to GRZ midwives and nurses who normally work at sites where DFPP outreach is provided. This training should be provided by the DFPPs during regular DFPP clinic visits and should include on-going mentoring and supervision.
- As GRZ staffing levels improve, local HCWs should assume responsibility for providing LARC. HCWs at these sites should receive LARC in-service clinical training, followed by clinical mentoring by DFPPs and eventual discontinuation of the DFPP model at that site.

5. Improve local governance and management of FP services. (SMC1.3)

At provincial and district levels in Zambia, MNCH Coordinators provide oversight and management for a number of programs and services related to maternal, neonatal, and child health, including FP. Given the expansive scope of the FP-related work that will be required as part of the Eight-Year Plan, it is recommended that new FP Coordinator positions be created at the district and provincial level and that the FP responsibilities which are currently under the purview of the MNCH Coordinators be transferred to these new positions. The FP Coordinators may also assume responsibility for another area currently under the MNCH Coordinator, such as eMTCT or adolescent sexual and reproductive health.

For scale-up of LARC in Zambia, the Provincial FP Coordinator will:

- Supervise District FP Coordinators
- Monitor LARC service provision in the districts, identifying underperforming districts and troubleshooting challenges
- Plan, execute and supervise in-service trainings with District FP Coordinators
- Ensure that equipment, commodities and consumables required for LARC reach districts in sufficient quantities

For scale-up of LARC in Zambia, the District FP Coordinator will:

- Map where and when LARC is provided in the District through site visits and coordination with NGOs.
- Identify gaps in LARC services: RHCs, UHCs and hospitals where LARC is not currently provided and RHCs, UHCs and hospitals where LARC is currently provided but LARC demand is not currently met.
- Coordinate LARC services, including working with health facilities to optimize the organization of FP services where LARC is currently provided and coordinating the establishment, scheduling and advertising/community mobilization of DFPP clinics.
- Monitor LARC services, including tracking occurrence of DFPP clinics, supervising DFPPs, and tracking volume of LARC provided.
- Ensure that equipment, commodities and consumables required for LARC reach facilities in sufficient quantities
- Plan, execute, and supervise in-service trainings with District FP Coordinators

6. Improve availability of LARC commodities and associated consumables. (PSC1, PSC3 – 5)

As detailed above, the district and provincial FP Coordinators should work with the RH Logistics Coordinator to monitor the flow of commodities and consumables from the central store to the facility level. District FP Coordinators should alert Provincial FP Coordinators when district supplies are running low. Provincial FP Coordinators can help to manage stock across districts, redirecting as needed. HCWs can also reach out to District FP Coordinators when they experience low inventory or stock outs of implants and IUDs, so that Coordinators can help to troubleshoot challenges. In addition, the FP coordinators should identify facilities with overstocks of the commodities and examine why uptake is low. Facilities that are not requesting LARC should be identified and contacted to understand why they are not managing implants and IUDs.

A system to routinely supply DFPPs with commodities and consumables should be established at the district level. DFPPs should also provide regular mentoring to HCWs on management of their own inventory. While supply of consumables has not yet become a major barrier to provision of LARC in Zambia, this is likely because many NGOs provide their own consumables when they conduct outreach services. As GRZ facilities scale up provision of LARC, the supply of consumables should be closely monitored. Co-packaging of consumables with implants and/or IUDs should be explored to prevent significant supply challenges in the future.

Table 17: Summary of LARC activities in the plan

Strategy		Activity	Corresponding 8 Year Plan Activity	Total 8 Year Cost (USD)	Budget Comments
1. Increase knowledge of LARC by educating providers and raising public awareness.	a.	Develop specific LARC messaging about LARC availability, efficacy and benefits, as well as myths and misconceptions, to be included in national FP BCC campaign	D1.1	$3,472.22	25% of total costs in budget
	b.	Print education materials so that every service delivery point is equipped with posters demonstrating all FP methods; fact sheets/flyers specific to LARC; and posters for HCWs on implant and IUD insertion and removal techniques.	D1.3	$413,000.00	2 posters and 200 brochures per SDP
	c.	During health campaigns, referrals for IUDs and implants will be made to nearby health centers, in addition to general LARC promotion, as part of the campaign.	D1.4	$0.00	No associated costs
	d.	Review and revise in-service and pre-service curricula for doctors, nurses, midwives, CHAs, and CBDs to ensure that familiarity with LARC, comprehensive FP counseling, and referral for services not provided by the HCW are included	SDA2.2, SDA5.1	$0.00	Inservice training curriculum costs are in 3.3. Preservice curriculum costs are found in 2.1
2. Strengthen pre-service clinical training of providers	a.	Revise curriculum for pre-service LARC practical training to ensure it is competency-based	SDA5.1	$13,644.07	Consultant, meeting and printing costs
	b.	Train clinical instructors and nursing tutors in LARC practical skills	SDA5.1	$197,116.30	
	c.	Revise HCW registration requirements for LARC to improve standards for LARC certification	SDA5.2	$5,310.74	Meeting costs
	d.	Purchase and distribute sufficent pelvic and arm	SDA5.1	$134,880.00	120 each of pelvic

Strategy		Activity	Corresponding 8 Year Plan Activity	Total 8 Year Cost (USD)	Budget Comments
		models for training institutions so that trainees can practice insertions and removals.			models, arm models and gynecological simulators
	e.	Work with CBDs to mobilize clients at training institutions during LARC pre-service training to ensure trainees have sufficient clients to practice skills.	SDA5.1	$0.00	Included in existing CBD costs
	f.	Expand pre-service clinical attachment training sites to include DFPP sites for LARC practical training	SDA5.1	$0.00	Costs covered by DFPP providers
3. Provide cost-effective in-service clinical training to a subset of strategically selected providers	a.	Develop the national in-service FP training plan, with particular goals to decentralize training, emphasize LARC, improve impact, and increase cost-effectiveness	SDA2.1	$24,704.81	
	c.	Revise and disseminate in-service training materials for LARC	SDA2.2	$12,352.41	
	d.	Purchase and distribute sufficent pelvic and arm models for inservice sites so that trainees can practice insertions and removals.	SDA3.4	$112,400.00	5 models purchased for each of the 20 institutions
	e.	Identify hospitals and well-staffed HCs where LARC is not but could be provided at a level to meet demand (high-priority facilities)	SDA1	$15,812.96	25% of survey costs
	f.	Execute in-service LARC training according to national training plan at targeted, high-priority facilities	SDA4.1, SDA4.2	$5,053,342.78	Costed for 500 HCWs per year
	g.	GRZ nurses and midwives who work at DFPP outreach sites receive inservice formal training in LARC, with DFPP providing practical LARC training and mentorship during DFPP outreaches	SDA4.1	$0.00	Included above in 3f
4. Modify the service	a.	Assess capacity of RHCs and UHCs to provide	SDA1	$0.00	Included above in 3e

Strategy		Activity	Corresponding 8 Year Plan Activity	Total 8 Year Cost (USD)	Budget Comments
delivery model for LARC		FP, particularly LARC			
	b.	Equip service delivery points with necessary FP equipment	SDA10.1	$3,129,451.85	Significant investment in 2014; some budget for refurbishments in 2017 and 2019
	c.	Optimize LARC service delivery where LARC is currently provided as part of routine FP services	SDA4.1	$0.00	Part of routine supportive supervision and role of FP coordinator
	d.	Develop comprehensive implementation plan for DFPP teams	SDA4.3	$12,352.41	
	e.	Choose sites to receive DFPP services using data from facility assessments and coordinating with existing NGO DFPP outreach services	SDA4.3	$0.00	
	f.	Recruit and train DFPP clinical and non-clinical staff	SDA4.3	$98,053.33	Costed to train 50 providers per year
	g.	Procure equipment needed for DFPP outreach services	SDA10.1	$0.00	Costs included in 4b above
	h.	Deploy DFPP outreach teams to support provision of FP, particularly LARC at RHCs and UHCs	SDA6	$7,319,433.33	Cost is for one midwife per district to visit sites once per month. Fuel included.
	i.	Adust which facilities receive DFPP outreach, schedule and frequency of outreach visits (weekly, monthly, quarterly) based on demand and facility's local capacity to meet demand for FP services, particularly LARC	SDA6.1	$0.00	No associated costs
	j.	DFPP outreach providers train local nurses and midwives in managing LARC side-effects and	SDA6.1	$0.00	Costs build into 4.8 above

Strategy		Activity	Corresponding 8 Year Plan Activity	Total 8 Year Cost (USD)	Budget Comments
		complications			
	k.	CBDs associated with HCs provide patient mobilization prior to outreaches	SDA7		Included in existing CBD costs
	l.	Expand CHA scope of work to include implant insertions by exploring feasibility, adjusting policy, developing training materials, and rolling out training	SDA9.1	$348,454.81	
5. Improve local governance and management of FP services	a.	Refine role of Provincial and District FP Coordinators, including responsiblities to be transferred from MNCH Coordinators.	SMC1.3	$0.00	Included below
	b.	Recruit, hire and orient Provincial and District FP Coordinators	SMC1.3	$76,914.07	
6. Improve availability of LARC commodities and associated consumables	a.	Provincial FP Coordinator to be involved in annual quantification, forecasting and procurement workshops for FP commodities and consumables and quarterly review meetings	PSC1	$195,320.00	Meeting costs
	b.	Develop supply system for DFPP teams to receive FP methods and consumables	PSC4.2	$0.00	RH Logistics Coordinator's responsibility - no additional cost required
	c.	Provincial and District FP Coordinators work with DFPP outreach teams, HC staff and MSL to address challenges with the distribution and requisition of FP commodities and consumables.	PSC5	$0.00	Part of existing job responsibilities
	d.	Consider co-packaging of LARC commodities and consumables	PSC1.2	$0.00	If chosen, co-packaging would be pursued at the procurement level

References and Notes

Table 18: LARC-related activities by Province, District and NGO

		LARC fixed NGO site			LARC outreach NGO site(s)			Some LARC training				
Province	**District**	**MSI**	**PPAZ**	**SFH**	**MSI**	**PPAZ**	**SFH**	**MSI**	**PPAZ/ ZISSP**	**SFH**	**SUFP**	**Jhpiego**
Central	Chibombo					x	x			x	x	
	Kabwe						x		x	x	x	
	Kapiri Mposhi						x		x	x		
	Mkushi						x			x	x	
	Mumbwa						x		x	x		
	Serenje								x			
Copperbelt	Chililabombwe			x			x			x		
	Chingola			x		x	x			x		
	Kalulushi						x			x		
	Kitwe		x	x		x	x			x		
	Luanshya						x		x	x		
	Lufwanyama						x		x	x		
	Masaiti						x		x	x		
	Mpongwe						x			x		
	Mufulira					x	x			x		
	Ndola			x			x			x		
Eastern	Chadiza											
	Chipata			x			x			x	x	
	Katete						x			x	x	
	Lundazi						x		x	x		
	Mambwe						x		x	x		
	Nyimba						x		x	x		
	Petauke						x			x		x
Luapula	Chienge						x			x		
	Kawambwa						x			x		
	Mansa	x		x			x			x		x
	Milenge						x			x	x	
	Mwense						x			x	x	
	Nchelenge						x			x		
	Samfya						x			x	x	
Lusaka	Chongwe						x			x		
	Kafue						x			x		
	Luangwa						x			x		
	Lusaka	x	x		x		x	x		x		
Muchinga	Chama						x			x	x	
	Chinsali										x	
	Isoka						x			x	x	
	Mpika						x		x	x		
	Nakonde		x						x			
Northern	Chilubi								x			

		LARC fixed NGO site			LARC outreach NGO site(s)			Some LARC training				
Province	**District**	**MSI**	**PPAZ**	**SFH**	**MSI**	**PPAZ**	**SFH**	**MSI**	**PPAZ/ ZISSP**	**SFH**	**SUFP**	**Jhpiego**
	Kaputa										x	
	Kasama			x			x			x	x	
	Luwingu						x			x	x	
	Mbala						x		x	x		
	Mporokoso						x			x	x	
	Mpulungu										x	
	Mungwi						x			x	x	
North-Western	Chavuma										x	
	Kabompo										x	
	Kasempa										x	
	Mufumbwe											
	Mwinilunga								x			
	Solwezi						x		x	x		
	Zambezi								x			
Southern	Choma						x			x		
	Gwembe											
	Itezhi-Tezhi						x			x		
	Kalomo						x			x		
	Kazungula					x	x			x		
	Livingston		x			x	x			x		
	Mazabuka			x			x			x		
	Monze						x			x		
	Namwala											
	Siavonga										x	
	Sinazongwe						x			x		x
Western	Kalabo						x		x	x		
	Kaoma						x			x	x	
	Lukulu								x			
	Mongu			x			x			x	x	
	Senanga						x			x	x	x
	Sesheke										x	
	Shangombo								x			

Notes

MSI (Marie Stopes International) currently provides FP services, which focus on LARC, at a few fixed sites and 100 outreach sites. MSI trains the HCWs at its outreach sites to provide LARC and provides them with necessary equipment. All of the outreach sites are fixed GRZ or mission-run clinics. Projected LARC volumes for 2013 are 18,000 implants, 7,000 IUDs

PPAZ (Planned Parenthood of Zambia) currently provides FP services, which focus on LARC, at 3 fixed sites and 17 outreach sites in nine districts. Some PPAZ outreach sites are GRZ or mission-run clinics; others use a tent or mobile clinic set-up. PPAZ has been under contract with MCDMCH/ZISSP to provide LARC training to nursing tutors, provincial trainers, clinical LARC mentors and HCWs.

SFH (Society for Family Health, a Population Services International affiliate) currently provides FP services, which focus on LARC, at 22 fixed sites and 519 outreach sites. All of the outreach sites are GRZ or mission-run clinics. Projected LARC volumes for 2013 are 50,000 implants and 10,000 IUDs.

SUFP (Scaling-Up of Family Planning in Zambia) is a training and mobilization project involving 26 districts in Zambia. HCWs at GRZ and mission-run facilities within the SUFP districts are currently being trained in logistics, FP (including LARC) and community mobilization.

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