The United Republic of Tanzania

Ministry of Health and Social Welfare

National Family Planning Costed Implementation Program

2010 - 2015

Reproductive and Child Health Section. March 2010

UNITED REPUBLIC OF TANZANIA

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Abbreviations

ADB	Asian Development Bank
ADDOs	Accredited drug dispensing outlets
ANC	Antenatal care
ACQUIRE	ACcess, Quality, and Use In REproductive health
BCC	Behaviour change communication
CBD	Community-based distribution
CBOs	Community-based organizations
CBS	Community-based services
CCHP	Council Comprehensive Health Plans
CHMT	Council Health Management Team
CIDA	Canadian International Development Agency
CMT	Country Management Team
CPR	Contraceptive prevalence rate
CSOs	Civil society organizations
CTU	Contraceptive technology update
DfID	Department for International Development (United Kingdom)
DHS	Demographic and Health Survey
DMPA	Depot-medroxyprogesterone acetate
DRCHCo	District Reproductive and Child Health Coordinator
FBOs	Faith-based organizations
FHI	Family Health International
FP	Family planning
GTZ	Gesellschaft für Technische Zusammenarbeit
HMIS	Health management information system
HPI	Health Policy Initiative
HRHSP	Human Resources for Health Strategic Plan
HSSPIII	Health Sector Strategic Plan III
IEC	Information, education and communication
IPPF	International Planned Parenthood Federation
IUDs	Intrauterine devices
KfW	Kreditanstalt für Wiederaufbau
LAPMs	Long-acting and permanent methods
LGAs	Local government authorities
M&E	Monitoring and evaluation
MCH	Maternal and child health
MDGs	Millennium Development Goals
MoFEA	Ministry of Finance and Economic Affairs
MoHSW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
MTEF	Medium-Term Expenditures Framework
MWRA	Married women of reproductive age
NBS	National Bureau of Statistics
NFPCIP	National Family Planning Costed Implementation Program
NGOs	Non-governmental organizations
NORAD	Norwegian Agency for Development Cooperation
PAC	Post abortion care
PHSDP	Primary Health Services Development Programme
PNC	Postnatal care
POPC	President's Office Planning Commission
PMO–RALG	Prime Minister's Office–Regional Administration and Local Government
PROGRESS	Program Research for Strenghthening Services
PSI	Population Services International
PSU	Pharmaceutical Support Unit
RCHCo	Reproductive and Child Health Coordinator
RCHS	Reproductive and Child Health Section
RH	Reproductive health
RMO	Regional Medical Officer
RMT	Regional Management Team
SAAs	Strategic Action Areas
SAAWGs	Strategic Action Area Working Groups
SDP	Service delivery point
SIDA	Swedish International Development Cooperation Agency
SPAS	Service Provision Assessment Survey
SRH	Sexual and reproductive health
STIs	Sexually transmitted infections
SWAps	Sector-wide approaches
TACAIDS	Tanzania Commission on AIDS
TFDA	Tanzania Food and Drug Authority
T-MARC	Tanzania Marketing and Communications Company
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
UMATI	Chama Cha Malezi Bora Tanzania
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	Women of reproductive age
YFS	Youth-friendly services

Foreword

Family planning saves the lives of women, newborns, and adolescents as well as contributes to the nation's socioeconomic development. Family planning prevents maternal mortality, one of the major concerns addressed by various global and national commitments and reflected in the targets of the Millennium Development Goals, Tanzania Vision 2025, the National Strategy for Growth and Reduction of Poverty, and the Primary Health Services Development Program, among others. Family planning also reduces infant deaths from AIDS by preventing unintended pregnancies and hence mother-to-child transmission of HIV. Family planning also helps governments achieve national and international development goals because it can contribute to the achievement of all of the United Nations' Millennium Development Goals, including reducing poverty and hunger, promoting gender equity and empowering women, reducing child mortality, improving maternal health, combating HIV/AIDS, and ensuring environmental sustainability.

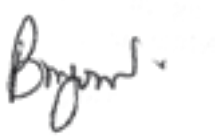
Over the last decade, however, other competing health priorities, such as tuberculosis, malaria, and HIV/AIDS have reduced the resources and visibility enabling Tanzania's family planning program to keep pace with unmet needs for these services. As such, the momentum of family planning programs has slowed considerably since 1999. Whilst modern method prevalence increased from 6.6 percent in 1992 to 13.3 percent in 1999, the annual increase in prevalence has dropped by 0.2 percentage points per year since then, with prevalence reaching only 26.4 percent in 2004–2005. At the same time, Tanzania has faced rising demands for family planning services, increasing from 38.3 percent in 1991–1992 to 49.5 percent in 2004–2005.

The Ministry of Health and Social Welfare (MOHSW) developed this National Family Planning Costed Implementation Program (NFPCIP) based on the goal of the One Plan to increase the contraceptive prevalence rate to a target of 60 percent by the year 2015. The NFPCIP is also guided by and links with the Health Sector Strategic Plan III (HSSPIII), the Human Resources for Health Strategy Plan (HRHSP), and the Primary Health Service Development Programme (PHSDP). Funds required to implement these NFPCIP activities will build on and augment the many investments called for in the HSSPIII, PHSDP, and HRHSP strategies by ensuring that essential resources for an effective family planning program are identified and that the activities are integrated and implemented within and throughout the overall health system.

The main objective of the NFPCIP is to reposition and reinvigorate access to and use of family planning services in Tanzania. The NFPCIP stipulates five strategic action areas for implementation that are needed to reposition family planning: contraceptive security, capacity building, service delivery, health systems management, and advocacy. Although all five components are needed for a thriving and effective program, emphasis will be given to two areas to prioritize fulfilment of the increasing demands for family planning services in the country. These two areas include ensuring contraceptive security and strengthening integrated service delivery of family planning in all aspects of the health sector, including HIV/AIDS, immunization services, postnatal care, and postabortion care.

Implementation of this plan requires that strategies and actions be integrated into the medium-term expenditure frameworks of government ministries and into the budgets of local government authorities. It is also the expectation of the Government, particularly the MoHSW, that development partners and all stakeholders will make optimal use of this NFPCIP to support the implementation of a reinvigorated family planning program and reach our target rate of contraceptive prevalence of 60 percent by 2015.

Having developed the NFPCIP, the Government of Tanzania is strongly committed to its successful implementation. All stakeholders have an obligation to participate to reposition and reinvigorate access to and use of family planning services in Tanzania. We thank all stakeholders for working to achieve the development of this plan. Together, we can improve the health of Tanzanian mothers, babies, and children, and build a stronger and more prosperous nation.



Blandina S. J. Nyoni
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Finally, the Ministry would like to acknowledge the RCHS for leading the coordination of all stakeholders engaged in the development process of this document.

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Executive Summary

Meeting the 'One Plan' Goal for Family Planning

A continuing high rate of population growth is presenting major challenges to social and economic development in Tanzania. According to the National Bureau of Statistics (NBS), at the current annual rate of growth of 2.9 percent, Tanzania's population is projected to reach 65 million by 2025, putting increased strain on already overstretched health and education services, infrastructure, food supply, and the environment. Early initiation of childbearing and a high rate of fertility are the principal factors contributing to this rapid population growth, and they also have detrimental effects on the health of women and children. Tanzania has among the highest rates of maternal, newborn, and child deaths in the world. Gender issues play important roles in both affecting access to health and economic resources for women and limiting the roles women can play in the country's social and economic development. Early childbearing usually curtails educational attainment for girls and constrains women's participation in economic productivity.

Family planning (FP) has for several decades been well documented as a key strategy to promote social and economic development, and to improve the health of women and their children. The *National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008–2015* (One Plan) has set a goal to increase the contraceptive prevalence rate (CPR) from 20 percent to 60 percent by 2015, by making quality FP services more accessible to and equitable for all of Tanzania's people. Increased use of FP has a great potential to contribute to the One Plan target of reducing maternal mortality from 578 to 193 per 100,000 live births by 2015. However, the Tanzania's FP program has lost momentum over the past decade because of a number of factors. As a result, the national CPR for modern methods among married women of reproductive age at the time of the last Demographic and Health Survey (DHS) in 2004–2005 had reached only 20 percent, and the annual rate of growth in CPR had slowed from a high of 1.5 percentage points to 0.6 percentage points. With the current level of investment in FP and the current rate of growth, the One Plan target will not be reached until 2030, with considerable negative consequences for the health and well-being of Tanzania's people and increased challenges to the country's economic development. It was noted in a recent study on National Health Accounts that expenditures for FP had decreased drastically, from 54 percent of reproductive health (RH) spending in 2003 to 8 percent in 2006. Deliberate efforts must be taken to rectify the situation. A renewed commitment to FP, a reinvigorated program, and significant investment of resources are thus required to achieve the One Plan target.

In recognition of the need to reinvigorate the national FP program, the Ministry of Health and Social Welfare (MOHSW) embarked on development of a costed implementation program for a 'repositioned' national FP program. The National Family Planning Costed Implementation Program (NFPCIP) is guided by the vision and mission of the Reproductive and Child Health Policy Guidelines 2003 and the goals of the one plan, setting targets for increased use of all FP methods by all women of reproductive age. The NFPCIP takes into consideration and builds on the substantial investments called for in other strategic plans and documents, namely the Health Sector Strategic Plan III (HSSPIII) July 2009–June 2015, the Primary Health Services Development Programme (PHSDP) 2007–2017, and the Human Resources for Health Strategic Plan (HRHSP) 2008–2013.

Through a collaborative, participatory, and consultative process involving a wide range of stakeholders, five strategic action areas (SAAs) have been defined, based on the issues and challenges that must be addressed to reposition FP successfully. These are ensuring **contraceptive commodities and logistics** (adequate and timely supplies of contraceptive methods appropriate to meet individual needs); renewed efforts in **capacity building** to ensure that providers in the health sector have the skills required to provide and support integrated FP services; strengthened **service delivery systems** to increase access to quality, affordable, and sustainable services; a renewed focus on **advocacy** to increase visibility of and support for FP among development partners, program managers, service providers, and the public; and strengthening **management systems, monitoring and evaluation** (M&E) to ensure effective program implementation.

Estimating the Level of Financial Support for Repositioning Family Planning

Table 1 provides a summary of funding in Tanzanian shillings and U.S. dollars needed each year through 2015, by Strategic Action Area (SAA), to reach a national average CPR target of 60 **percent for all methods for all women of reproductive age by 2015**. Guided by an analytical framework that projects needs based on the current population structure and growth rates, and considers the diverse situations in mainland Tanzania's 21 regions, these estimates were derived through an iterative process to define and prioritize activities that will be required to achieve the objectives in each of the five SAAs. Through this process, a total of 28 strategic actions were defined across all five areas. These were further broken down into specific activities, with timelines and inputs required for implementation. Unit costs of the inputs were then used to estimate the cost for each activity each year.

The activities and the costs of the inputs needed for each SAA serve as a platform for mobilizing resources as well as for tracking implementation and measuring the impact of the NFPCIP. Careful review of the HSSPIII, PHSDP, and HRHSP have been undertaken to ensure **no duplication of the investments and that the NFPCIP is integral of these strategic health programs**. Although investments in these strategic health programs will benefit the entire health sector, including FP, the resource needs identified in the five SAAs of the NFPCIP are the additional investments that will be required specifically to strengthen FP through a coordinated approach to achieve the One Plan target.

Table 1. Annual Funding Requirements, 2010–2015, by Strategic Action Area to Reposition Family Planning, with 60 percent CPR Target Achieved by 2015 (in Tshs/USD)

STRATEGIC ACTION AREA	FISCAL YEAR						TOTAL COST ESTIMATE
	FY 2010–2011	FY 2011–2012	FY 2012–2013	FY 2013–2014	FY 2014–2015	FY 2015–2016	
I. Contraceptive security & logistics	16,282,691,047	17,592,358,355	18,700,234,439	20,617,616,767	22,733,318,127	25,403,005,311	121,329,224,046
II. Capacity building	1,211,037,000	1,619,613,533	913,909,250	730,794,500	604,212,000	604,112,000	5,683,678,283
III. Service delivery	465,895,283	917,230,750	570,577,000	96,353,750	99,935,000	64,000,000	2,213,991,783
IV. Advocacy	1,129,514,330	583,857,580	743,772,250	133,831,250	133,831,250	118,047,750	2,842,854,410
V. Management systems/M&E	549,527,800	202,613,800	134,500,300	77,746,300	72,346,300	84,496,300	1,121,230,800
Total (in Tshs)	**19,638,665,461**	**20,915,674,018**	**21,062,993,239**	**21,656,342,567**	**23,643,642,677**	**26,273,661,361**	**133,190,979,323**
Total (in USD$)	**14,547,160**	**15,493,092**	**15,602,217**	**16,041,735**	**17,513,809**	**19,461,971**	**98,659,985**

Exchange rate: 1 USD = 1,350 Tshs.

Introduction

Background

The health benefits of Family Planning (FP) for women and their children have been well documented for several decades, as has its essential contributions to social and economic development. Limited FP services have been available in a few urban areas of Tanzania since the establishment of the family planning association of Tanzania (UMATI) in 1959. Beginning in 1974, the Government of Tanzania allowed UMATI to expand FP services to public-sector maternal and child health (MCH) clinics throughout the country, but expansion was limited because of resource constraints, and levels of contraceptive use remained low.

Expansion of the program and growth in the contraceptive prevalence rate (CPR) were accelerated after a speech by the late first President Julius Kambarage Nyerere in 1989 that recognized the importance of FP to Tanzania's development. In 1989, the Tanzanian government assumed responsibility for integrating FP into government MCH services from UMATI. During the next few years—the 'golden age' of FP in Tanzania—the prevalence of modern FP method use more than doubled, increasing from 6.6 percent in 1992 to 13.3 percent in 1996, growing at an average of 1.5 percentage points per year. Beginning in 2000, however, the increase in prevalence dropped to 0.6 percentage points per year, with contraceptive prevalence for all methods among married women of reproductive age reaching only 26.4 percent by the time of the last Demographic and Health Survey (DHS) in 2004–2005.

A number of factors contributed to the loss of momentum, including decentralization and integration of health programs and the shift in donor funding mechanisms and priorities. As FP priority, visibility, and financial support declined, the fundamental elements needed to sustain a thriving FP program were also weakened at central, regional, and district levels. These elements include a consistent and adequate supply of contraceptive commodities to meet increasing demand, capacity building to increase the number of skilled FP providers and ensure updated provider skills, well-equipped and flexible service delivery systems, education and motivation to generate demand for services, advocacy to sustain support for FP from various funding sources, and effective management systems and leadership to guide program implementation.

Repositioning FP as a priority in the national agenda is a key strategy to improve maternal, newborn, and child health; to prevent mother-to-child HIV transmission; and to promote social and economic development. Renewed advocacy for FP and adequate funding for program implementation to meet these goals are therefore urgently needed.

Family Planning: a Cost-Effective Investment to Improve the Health, Well-Being, and Quality of Life of Tanzania's People

Health and demographic indicators are the widely accepted measures used to assess a country's health situation. Key indicators for Tanzania are shown in Table 2. Tanzania has a young population, with early childbearing and high rates of fertility continuing throughout reproductive life. These factors account for the projected near-doubling of the population by 2025, placing increasing stresses on health and education systems, availability of food and clean water, natural resources and the environment, and economic growth and development. All of the girls who will enter childbearing age over the next decade have already been born, and with almost half of the country's population

under age 15, Tanzania's population growth will only accelerate. Early initiation of childbearing and numerous, closely-spaced pregnancies throughout a woman's reproductive life contribute not only to rapid population growth but also to adverse social consequences such as gender inequity. Girls who experience their first pregnancy during adolescence often terminate their education, limiting their future participation in positive social and productive economic activity. In addition, early and frequent childbearing has serious health consequences for girls and women, contributing to higher rates of complications such as eclampsia, obstructed labour, haemorrhage, anaemia, premature delivery, and death.

Table 2. Tanzania Demographic and Health Indicators

INDICATOR	
Population in millions, Tanzania mainland (2002 census)	34.4
Projected population in millions, 2004, Tanzania mainland (2004–2005 DHS)	36.0
Projected population, 2025, in millions (NBS)	65.3
Annual population growth rate (2002 census)	2.9
Percent of population under age 15 (2002 census)	47.0
Percent of women pregnant or with live birth by age 19 (2004–2005 DHS)	52.0
Total fertility rate (2004–2005 DHS)	5.7
CPR, modern methods (2004–2005 DHS)	20.0
Unmet need for FP (2004–2005 DHS)	21.8
Maternal mortality per 100,000 live births (2004–2005 DHS)	578
Infant mortality per 1,000 live births (2007 THMIS)	58

DHS = Demographic and Health Survey; NBS = National Bureau of Statistics; THMIS = Tanzania HIV/AIDS and Malaria Indicator Survey.

Maternal mortality rates in Tanzania are among the highest in the world. Abortion is illegal in Tanzania, and abortion complications are estimated to contribute to about 16 percent of maternal deaths. Family planning services can significantly reduce unintended pregnancies and maternal mortality from unsafe abortions. Maternal mortality rates in Tanzania could be reduced by as much as 35 percent if the One Plan FP goal is achieved.

High rates of infant and child deaths are another consequence of early and frequent childbearing and of childbearing late in life (after age 35). Despite significant progress in reducing the infant mortality rate, this rate remains high in Tanzania. Significant reductions in infant mortality can also be realized by a reinvigorated FP program, saving the lives of half a million children over a 10-year period.

Access to safe, effective, acceptable, and affordable FP methods and services is a key, highly cost-effective intervention to save lives and reduce the adverse social and economic consequences of rapid population growth. As shown in Table 2, at the time of the 2004–2005 DHS, more Tanzanian women expressed an unmet need for FP than were actually using an FP method. An estimated 2.9 million unintended pregnancies could be averted over the next decade if the unmet need for contraception were met. Although achieving the One Plan target will require increased demand for FP, meeting the currently high level of unmet need alone would make a substantial contribution toward achieving the goal.

Increased availability and use of FP is a key strategy for preventing HIV/AIDS. Consistent and correct use of condoms is an important means of preventing transmission of HIV and other sexually transmitted infections (STIs). Family planning is also a highly cost-effective means of preventing mother-to-child transmission of HIV (PMTCT). Among infected women who do not wish to become pregnant, providing effective contraception to prevent an unintended pregnancy costs a fraction of providing antiretroviral drugs for PMTCT or of caring for AIDS orphans.

Investments in FP will contribute substantially to achievement of six of the eight Millennium Development Goals (MDGs): reducing poverty and hunger, promoting gender equity and empowering women, reducing child mortality, improving maternal health, combating HIV/AIDS, and ensuring environmental sustainability. Family planning is a priority in the national development agenda, and its visibility must be enhanced so that increased access to and use of FP methods and services can make important contributions to achieving the country's overall health and development goals.

Programs and Resources for Health and Family Planning Services

An estimated 80 percent of FP services are provided by decentralized public-sector health facilities through 133 local government authorities (LGAs). These include regional and district hospitals, health centres, dispensaries, and community health services. In addition to the public-sector facilities, a number of hospitals, health centres, and dispensaries managed by faith-based organizations (FBOs) and standalone FP/RH clinics managed by nongovernmental organizations (NGOs) also provide FP services. Further, all public, FBO, and NGO facilities obtain their FP commodities through the national level Medical Stores Department (MSD). A limited number of private, for-profit clinics, pharmacies, and drug stores also provide some FP products and services, but data are lacking on the numbers and distribution of such providers. Appendix A lists the planning partners and implementers for the national FP program in the year 2009–2010.

An important step in implementing a reinvigorated FP program is to ensure that the process of budgeting and financing for RH services and contraceptive commodities are understood by the Council Health Management Team (CHMT). Requests from the CHMT are forwarded, usually in November, through the Regional Medical Officer (RMO) to the Ministry of Finance and Economic Affairs (MoFEA), which allocates governmental and Basket resources through the Medium-Term Expenditures Framework (MTEF) in accordance with ceilings set through negotiations among the MoHSW, MoFEA, President's Office Planning Commission (POPC), and the Prime Minister's Office–Regional Administration and Local Government (PMO–RALG). At each level, additional justification or clarification may be required for the budget requests, until a final approved budget is submitted to Parliament in June. After approval by Parliament, the MTEF can dispense funds to the CHMTs, usually on a quarterly basis. The process generally takes about nine months from initiation until funds become available to support health services at the district and community levels.

The forecasting and quantification exercise, as well as the development of budgets and procurement plans for contraceptive commodities, are done at the central level. Then, funds are sent to the MSD for procurement and distribution of FP commodities to facilities. For funds that are administered through the Basket fund, an additional level of approval or no objection from the World Bank is required before ordering of contraceptive commodities. The standard time from when funds are released from the MoFEA until the commodities arrive at MSD is six to nine months.

Issues and Challenges of the Current Family Planning Program

The FP program faces a number of challenges and constraints that must be addressed for effective repositioning of FP to meet the country's RH and development goals. Five program areas or components are essential for implementing a successful FP program: a consistent and adequate

supply of contraceptive commodities; sufficient numbers of health providers who have the necessary knowledge and the technical and client interactions skills to deliver FP services safely and effectively; appropriately equipped facilities with a flexible array of service delivery modalities and systems to meet the needs in different sociocultural contexts and levels of development in Tanzania's different regions; strong advocacy to increase visibility and support for the program and address the knowledge-use gap among FP clients; and strong management systems and leadership to ensure efficient and effective program implementation. The issues and challenges for each area have been defined below based on a review of published literature and documents, through discussions with the National Family Planning Working Group and through a series of key informant interviews (see Appendix B for a summary report of these interviews).

I. Contraceptive Commodities and Logistics: Availability and Choices of Methods

Providing a choice of 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 in a program influences not only successful client use and satisfaction, but also has implications for provider skills and the facilities and equipment needed to deliver certain methods. All of these factors affect program cost and sustainability and, in turn, the amount of contraceptive protection that can be provided with various levels of financial support.

Maintaining an adequate supply of contraceptive commodities to meet clients' needs, **prevent stock-outs** and ensure **contraceptive security** is the most urgent issue facing the Tanzania's FP program. The inability to supply and sustain current users has considerable implications for expansion of the program to meet the CPR targets of the One Plan. Other key strategies (HSSPIII and PHSDP) recognize the importance of ensuring the availability of adequate contraceptive choices. General strengthening of logistics systems planned in the PHSDP will benefit contraceptive security, but additional investments are needed to ensure adequate forecasting, budgeting, and tracking of supplies so that all contraceptive methods, especially those that are in greatest demand, are available when and where clients need them.

Funding allocations through the MTEF are not adequate to meet contraceptive commodity requirements because of competing priorities in the health sector. However, the government is progressing well towards meeting the Abuja declaration target of 15 percent of the total national budget to cover improvement in the health sector.

Furthermore, when requests for funding from the district level are prioritized and submitted for funding by the district-level health management teams, FP falls well below other health service priorities in some districts and is sometimes overlooked in these requests. As a result, stock-outs of contraceptive commodities occur even when districts have returned unused funds to the Basket.

A key factor in ensuring contraceptive security, **method-mix issues,** has important implications for cost as well as for client acceptance and satisfaction needed to sustain successful use.

Short-acting methods are the most prevalent contraceptives in the current method mix, according to the 2004 DHS, which include pills, condoms, and, increasingly, injectable depot-medroxyprogesterone (DMPA). These methods require regular resupply, hence successful use must include access to a consistent supply of the product. Each 'resupply' visit to a service delivery point (SDP) entails additional costs. Pills and condoms also require high levels of **user adherence and motivation**, with inconsistent and incorrect use leading to method failures and high rates of discontinuation.

Condoms protect not only against unintended pregnancy but also against STIs, including HIV. They have been widely promoted in HIV-prevention programs and, less often, as 'dual protection' against pregnancy and STIs/HIV. Their association with STI and HIV prevention, however, means that for many couples, condoms are stigmatized as being associated with extramarital sex, and therefore partners may resist using condoms for pregnancy prevention.

Long-acting methods give contraceptive protection for a year or more. They include intrauterine devices (IUDs) and implants. These methods have higher initiation costs than short-acting methods, but because they can be used without resupply for several years, they are often less expensive per year of use. Initiation costs for these methods are higher because the costs of the commodities themselves are higher. In addition, they require providers to have special training and skills for insertion and removal as well as good counselling skills to ensure that clients can make informed choices about these long-acting methods. Unlike short-acting methods, which can be discontinued simply by the user stopping the method, discontinuation of IUDs and implants requires removal by a trained provider.

Prevalence of IUD use in Tanzania is low, despite it being the most cost-effective form of reversible contraception, having a good safety record, and providing highly effective contraceptive protection for up to 10 years. Expanding the use of IUDs will require considerable attention to addressing myths and misinformation about IUDs among both providers and clients. Hormone-releasing subdermal implants provide safe, highly effective contraception and have been growing in popularity among Tanzanian women.

Permanent methods of contraception (sterilization) include tubal ligation for women and vasectomy for men. Worldwide, these two surgical methods account for the majority of contraceptive users and are highly effective and safe when provided by trained personnel with appropriate attention to infection control. Although the prevalence of permanent methods is low in Tanzania, the use of tubal ligation is growing, especially for women who do not want more children, and a pilot program to provide vasectomy in the Kigoma region is meeting with considerable success. Provision of permanent methods is limited both by weaknesses in health facilities as well as by lack of provider skills. Additionally, widespread rumours—for example, equating vasectomy with castration—undermine acceptance of these highly effective methods. Because these methods limit future childbearing, client education and counselling to ensure informed choice and informed consent are essential parts of service provision. However, weaknesses exist in such client-provider interaction skills. Expanded availability of permanent methods for those who do not want more children can help Tanzania achieve its CPR targets, but this will require significant investments in capacity building to ensure proficiency in surgical skills, counselling, and informed consent procedures.

II. Capacity Building: Ensuring Provider Skills for Family Planning

Human resources are the most costly recurring expense in the health care system, with financial resources needed not only to recruit and retain health care workers but also to ensure that they have the knowledge, skills, and supervision to enable them to deliver safe, high-quality FP services. For effective repositioning of FP to occur, health workers at all levels must see providing family planning as their responsibility. National health-sector strategies (HSSPIII, HRHSP, and PHSDP) include objectives to ensure sufficient numbers of health care providers at all levels of the system. The NFPCIP will therefore focus on ensuring that health providers already in service, as well as those in training and those to be hired, have the appropriate knowledge, skills, supervision, and support to provide safe, effective, acceptable FP services.

There is a critical shortage of skilled health care workers in Tanzania. Inadequate capacity for planning, forecasting, and management of human resources are underlying factors affecting the shortage. Distribution and retention of health care workers is also problematic. After almost a decade-long employment freeze in the public sector during the Retrenchment Policy (1993–1999), efforts to recruit health personnel have begun again. However, many posts, especially at rural district levels, remain unfilled. Hardship living conditions in many districts, along with lack of retention schemes, limited training opportunities, and overwhelming responsibilities, are major factors undermining both recruitment and retention. According to a recent study, less than half of Tanzania's final-year medical students were willing to accept rural postings.

Low health worker productivity also contributes to the provider capacity challenge. Currently a 'pay-for-performance' initiative is underway to enhance health worker productivity, but it has no indicator for FP. Inclusion of an indicator for FP must avoid any target-setting that could be construed as coercive.

Capacity building of providers to ensure essential skills in FP is in critical need of focused attention. The national training strategy for FP is due for revision. Many current providers have not had their FP knowledge and skills updated in several years, undermining the quality of care they provide. A baseline survey of FP services in 2004–2005 found low levels of provider knowledge, clinical skills, and counselling capability needed to provide quality FP services for both short- and long-acting methods.

Provider biases and misinformation persist about certain methods and the appropriateness of FP methods and services for selected categories of clients (youth, HIV-infected, etc.). The six Zonal Training Centres, are charged with maintaining the knowledge and skills of current health providers. Pre-service training for health professionals in some 116 health training institutions (public and private sectors) must be strengthened.

Supervision needs strengthening, a fact recognized in the HRHSP, the HSSPIII, and the PHSDP. Among the reasons for low health worker morale and poor retention rates are the lack of structured and supportive supervision, including lack of written or oral feedback from supervision visits. Investments through other program initiatives can strengthen supervision capacity in general. Investments through the NFPCIP will help supervisors play more active roles in identifying providers who need FP skills updates and in ensuring that those who are trained are applying their updated knowledge and skills appropriately.

III. Service Delivery Systems

Access to a SDP is an essential component of FP. According to the Tanzania DHS 2004–2005, more than 90 per cent of Tanzanians live within 10 kilometres of a health facility. The Tanzania Baseline Survey conducted by the ACcess, Quality, and Use In REproductive health (ACQUIRE) project in 2004–2005 found major deficiencies in the abilities of both clinic and hospital sites to provide FP services, especially for long-acting and permanent methods (LAPMs). In areas where the nearest health care provider is an FBO, the availability of FP services depends on the religious beliefs and attitudes of the organization with regard to FP and contraception methods.

Infrastructure limits the types of FP services that can be provided in many health facilities. Higher-level facilities, such as regional and district hospitals, are better equipped and supplied than are health centres, and dispensaries. Some dispensaries and health centres, lack an on-site clean water source and electricity, both essential for providing quality services, including infection control, for LAPMs. Other infrastructure weaknesses include lack of private space for providing FP counselling

or services involving pelvic examinations and inadequate storage space for contraceptive supplies. As with other areas, the major investments in strengthening infrastructure are being made through the PHSDP and HSSPIII. The NFPCIP gives attention to ensuring that they are incorporated in planning for upgrading of health infrastructure and equipment.

Considerable progress has been made to ensure the availability of **equipment and supplies,** such as examining and surgical tables, lamps, sterile gloves, disposable needles, syringes, and containers for sharps disposal, that are needed to provide some FP methods safely. However, consistent supply in facilities, especially in community health facilities, needs to be further strengthened.

Utilization of services is influenced both by proximity and physical access to an SDP and by **client perceptions about the quality of care** they are likely to receive. Factors influencing client perceptions include the availability of counselling, information, and support provided to those seeking FP services and particularly the consistent supply of contraceptive methods.

Efforts are underway to foster the integration of FP with other sexual reproductive health services, such as FP and HIV/AIDS, FP and gender-based violence, FP in postnatal care (PNC), and FP in postabortion care (PAC). However, many missed opportunities remain to integrate, promote, and provide FP as part of other health services, such as with child immunization services. Integration of services will help to reach new populations who may need FP and who must be reached to achieve One Plan targets. Studies in other East African countries have shown that, even when providers of these services lack the time or skills to provide direct services, they can assess the need for FP and refer clients to an appropriate source.

Young people also need special attention, both in increasing their access to information, education, and friendly services and in helping them to choose and use contraceptive methods effectively. With adolescents constituting almost a third of Tanzania's population, early sexual debut, and high rates of pregnancy and childbearing among teenage girls, the needs for contraception are clear. The MoHSW/Reproductive and Child Health Section (RCHS) has developed a national strategy on adolescent RH that outlines key strategic objectives to enable adolescents to cope with their growing up in this transition period. Despite having the strategy, many gaps still remain in terms of fostering implementation of existing supportive policies and laws for young people to exercise their sexual and reproductive rights; access friendly RH information, education, and services; human resource capacity for providing services; and parent and community support towards young people.

Referral systems need strengthening by ensuring that the referring provider has knowledge of what FP services are available at referral centres, and has a mechanism to link clients to those centres,. This has also been emphasized in the PHSDP and HSSPIII. Closer linkages with private, NGO, and FBO facilities can be encouraged as part of the referral system.

In addition to clinic-based services, there are other options to deliver FP services. The decentralization of responsibility for health care to the community level in Tanzania opens the door for expansion of **community-based services (CBS).** Community-based services includes community-based distribution (CBD) of short-acting methods now underway in a limited number of regions in Tanzania, as well as making some methods available through accredited drug dispensing outlets (ADDOs) and through pharmacies. Several issues and challenges must be addressed in considering expansion of CBS, however. The CBD workers, as well as distributors in ADDOs and pharmacies, need training and supervision to provide contraception, and this can entail considerable costs. Also, CBD workers work on a voluntary basis; long-term retention of CBD workers requires that some attention be given to nonmonetary rewards or noncoercive incentives.

IV. Advocacy

The basis of any strong program is a strong supportive policy framework, with high-level advocates to maintain visibility and speak for the importance of the program. A supportive advocacy and policy environment improves access to services and addresses normative barriers that restrict provision of services. It mobilizes community and donor support for FP and is essential to secure financing for the program, a crucial component of maintaining contraceptive security. It is essential in promoting awareness of the benefits for FP and encouraging clients' access to and use of services. Strengthening capacity for advocacy called for in the PHSDP, and investments now underway to expand information and communications technologies, will help to address the need for increased advocacy for FP. The following paragraphs discuss the specific needs to be addressed through the NFPCIP to strengthen advocacy for FP in Tanzania.

Sectoral reforms and decentralization, which began in the late 1990s and is still ongoing, coincided with a slowing of the momentum achieved in the FP program in the mid- to late-1990s. The sector-wide approach (SWAp) for health builds on the recommendations from the 1994 International Conference on Population and Development to integrate health services into a comprehensive package that meets all client needs and reduces or eliminates vertical programs. Because FP contributes to improvements in social and economic development, improvements in the environment, and saving the lives of women, children, and adolescents, it is important to address FP in a multisectoral approach.

Along with the SWAp, efforts to decentralize health care and promote community involvement in and responsibility for health care were instituted. However, budget allocations still must be increased for FP services at the district level. The MoHSW has developed a package of essential interventions for empowering districts to include FP activities into Council Comprehensive Health Plans (CCHP) guidelines.

Policy issues also directly affect the **delivery of contraceptive methods and services**. Although policies set clear goals for making FP available to all who want and need services, without regard to age, marital status, sex, or ability to pay, they are limited as to which categories of health personnel are authorized to provide certain methods. These limitations must be reviewed according to the local situation and needs and international norms and guidelines informed by recent research and program evidence. Additionally, more effective dissemination of existing policies and guidelines, as well as of updates and revisions, is needed so that all those implementing FP services are aware of them.

Champions are important and needed to advocate for continued support and to promote use of FP. There is a need to identify and recruit additional champions as well as orient and support their activities at various levels.

Awareness levels of FP among Tanzanians are high. According to the 2004–2005 DHS, 96 percent of all women and 97 percent of all men had heard of FP. **However, knowledge does not equal use of FP services**. 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, fears of side effects and health concerns, poor access to services and methods, and concerns about costs. Public-sector facilities in Tanzania do not charge for FP methods and services; however, poor infrastructure, shortage of skilled providers, and inconsistent availability of contraceptive products all impede access to FP services by men, women, and adolescents.

In addition to those who fall within the traditional 'unmet need' category are all of those who remain unaware of FP and its benefits or of their eligibility to access and use FP. These may include women

in remote rural areas, youth, men, or groups with special needs, such as HIV-infected persons. Bridging the gap between current use and unmet need to reach the One Plan target of 60 percent CPR by 2015 will require expanded efforts to increase demand for and use of FP in these groups. Along with increasing demand is the need to ensure that services and commodities are available to meet it. Demand-generation activities must be paced so that new demand for methods and services can be met while current needs are being sustained. Planned investments in information and communications technologies in HSSPIII and PHSDP will be of great benefit to activities that aim to generate demand for FP.

V. Health Systems Management, Monitoring, and Evaluation

Clear **leadership and management responsibility and authority** are essential for repositioning FP overall and ensuring NFPCIP implementation. Increasing the number of RCHS staff and management training is needed. The main challenges to achieving the goals of the NFPCIP are that all of its elements must be fully funded and all recommended actions must be implemented on schedule. For example, capacity building to ensure adequate human resources assumes sufficient numbers of health care workers can be hired and trained. This will require full funding and implementation of the PHSDP and HRHSP as the platform upon which the NFPCIP is built. Achieving the goal also assumes there will be no unforeseen circumstances that will sidetrack implementation and that political and traditional leaders at the national and community levels will recognize and give priority to FP as a basic human right of their people.

Management systems and existing tools must be strengthened for successful repositioning of FP. Among the challenges that must be addressed are ensuring a clearer understanding, especially at the CHMT level, of how to prioritize FP in the budgeting process for the basket funding. Coordination among all of the different agencies and organization involved in FP, sharing operational information, and tracking implementation of the NFPCIP will require investments in strengthening both systems and management skills to accomplish these essential tasks, including increased attention to public-private partnerships for FP.

Monitoring and evaluation (M&E) systems also need strengthening, as recognized in HSSPIII. The 'way forward' calls for investments in developing a comprehensive M&E and research strategy for the health and social welfare sector that is integrated with the health management information system (HMIS). For the NFPCIP, this includes having adequately trained personnel to collect, report, analyze, and use FP data for oversight of plan implementation and to recognize needs for and make decisions about midcourse corrections to the NFPCIP.

Health sector reform, especially as noted in the HSSPIII, emphasizes **public-/private-sector partnerships**. However, such partnerships in the FP services area are weak and must be strengthened. The private, NGO, and FBO sectors can play an increased role in repositioning FP. Currently, the government of Tanzania accounts for almost 70 percent of FP services in the country. Increasing the role of the other sectors can help reallocate limited governmental resources to meet the needs of the poorest of Tanzania's citizens. It can also help generate demand by reaching new groups who are not yet users of FP or who do not yet perceive a need for FP.

National Family Planning Costed Implementation Program

Purpose of the NFPCIP

Recognizing the need to reposition family planning in Tanzania, the MoHSW has developed the NFPCIP. The development of the NFPCIP is guided by the vision and mission established in the Reproductive and Child Health Policy Guidelines of 2003. Furthermore, the goal of the NFPCIP is guided by the *National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008–2015* (One Plan) as well as by the HSSPIII. Both strategic plans recognize family FP as essential to improving maternal, newborn, and child health. Although the overall investments in the health sector called for in the HSSPIII, PHSDP, and HRHSP will strengthen the foundation for FP, the specific aim of the NFPCIP is to identify the activities to be implemented and additional resources that will be needed to make quality FP services more accessible to and equitable for all of Tanzania's people. Appendix C describes the process used to develop the NFPCIP and provides a list of the individuals and organizations that participated in this consultative, collaborative process.

The NFPCIP clearly defines priorities for strategic actions, delineates the activities and inputs needed to achieve them, and estimates the costs associated with each as a basis for budgeting and mobilizing resources required for implementation at different levels by organizations and institutions over the 2010–2015 period. In addition, the NFPCIP is intended to serve as a guide for development partners and implementing agencies on areas of need to ensure the success of the national FP program.

More specifically, the NFPCIP will be used to:

- Inform policy dialogue, planning and budgeting to strengthen FP as a priority area in the National Development Agenda;
- Prioritize FP program strategic actions and activities for implementation at different levels of the health system;
- Enable the MOHSW and other GoT sectors to understand the budgetary needs to implement a FP program to reach projected targets, and to make projections for the future as new demand for FP is generated;
- Mobilize and sustain quality resources (human, financial, technical, commodities and equipment) that are essential for achieving cost-effective and scaled-up services for FP; and
- Provide benchmarks and indicators that can be used by GoT and development partners to monitor and support the FP program;

Vision, Mission, Goals and Objectives of the NFPCIP

Vision:

A healthy and well-informed Tanzanian population with access to quality reproductive and child health services that are acceptable, affordable, and sustainable and provided through efficient and effective support systems.

Mission:

Promote, facilitate and support in an integrated manner the provision of reproductive and child health services to men, women, adolescents, and children in Tanzania.

Goal:

Increase the CPR among women of reproductive age from 28 percent to 60 percent by 2015.

The denominator used for the CPR target is women of reproductive age and not married women of reproductive age (MWRA). This is to take into consideration all women of reproductive age regardless of their marital status. Furthermore, the CPR target includes all methods and not just modern methods. According to the DHS 2004–2005, the CPR among MWRA for modern methods is 20 percent and the CPR among MWRA for all methods is 26.4 percent, while the CPR for women of reproductive age for all methods is 28 percent. The latter figure of 28 percent is thus used.

Although guidance is also provided by the HSSPIII, which has a goal CPR of 30 percent by 2015, the higher CPR goal of 60 percent specified by the One Plan was chosen so that repositioning FP can be addressed more aggressively and, as a result, will have greater potential impact on reducing maternal and newborn mortality and improving child survival.

Furthermore, there is a wide degree of variation across regions in current CPR as well as considerations of culture and context, such as the availability of infrastructure, human resources, service modalities, and current demand. These factors increase the challenges to be addressed and the level of resources that will be needed to reach the 60 percent CPR One Plan target by 2015. The regional variations and the different scenarios for repositioning FP are discussed in more detail in the Analysis of Demographic Determinants of Resource Requirements section.

Strategic Action Objectives:

The NFPCIP objectives reflect the five major program components that must be strengthened to address the issues and challenges to reposition FP as a national priority for health and development. Although all five components are needed for a thriving and effective program, emphasis will be given to two areas to prioritize fulfilment of the increasing demand for FP services in the country. These two areas include ensuring contraceptive security and strengthening integrated service delivery of FP in all aspects of the health sector, including HIV/AIDS, immunization services, PNC, and PAC.

1. Expanded availability and choices of safe, effective, acceptable, and affordable **contraceptive methods**.

   This objective addresses contraceptive logistics and security, ensuring that supplies of all contraceptive commodities are adequate to meet the needs and preferences of FP clients. It includes the registration and introduction of new or improved contraceptive methods that may become available.

2. **Capacity building** of providers to deliver and support safe, effective use of FP methods and services.

   This objective addresses the capacity of the people who deliver FP services. Capacity-building considerations include the numbers, categories, attitudes, skills, supervision, and remuneration of service personnel at all levels and in all sectors.

3. Strengthened **service delivery systems** and increased options for delivery of quality, affordable, and sustainable FP.

   This objective addresses service delivery systems, which are the organizational components that affect access to FP. They include facility- or clinic-based services, CBS, and other modalities and channels within and outside of the health sector. Service delivery systems include physical infrastructure, equipment, and supplies, as well as special considerations and opportunities, such as integration of services, to meet the needs of vulnerable populations such as youth, men, women receiving PNC or PAC, or HIV-infected women.

4. Reinvigorated **advocacy** to increase visibility of and support for FP as a key investment for improving the lives, health, and well-being of Tanzania's people.

   This objective addresses the underlying causes of loss of visibility and momentum in the current FP program and addresses the knowledge-use gap among FP clients. It is aimed at sustaining support for FP from the highest policy levels and at promoting public dialogue at all levels, national through community, about the important role of FP in promoting health and gender equity and supporting development. It also involves addressing policies that may impede achievement of the other objectives, such as restrictions on what level of provider is authorized to provide certain contraceptive methods, or how funds for programs are allocated and channelled. Addressing the knowledge-use gap will involve addressing myths and misinformation about FP and fear of side effects and health concerns that impede its adoption and use. Additionally, it addresses demand for FP that must go beyond maintaining current levels of use to meet unmet needs if the One Plan target is to be reached.

5. Strengthened **health systems management and M&E** of the national FP program.

   This objective addresses the need to reinforce the capacity of the MoHSW centrally as well as at the regional and district council levels. Effective management systems include making financial resources available in a timely manner to all implementing levels, coordinating with other ministries and implementing partners, regular tracking of activities and deliverables needed to achieve plan objectives, integrating with and using the HMIS, and using tracking and M&E data to improve program performance.

Analysis of Demographic Determinants of Resource Requirements

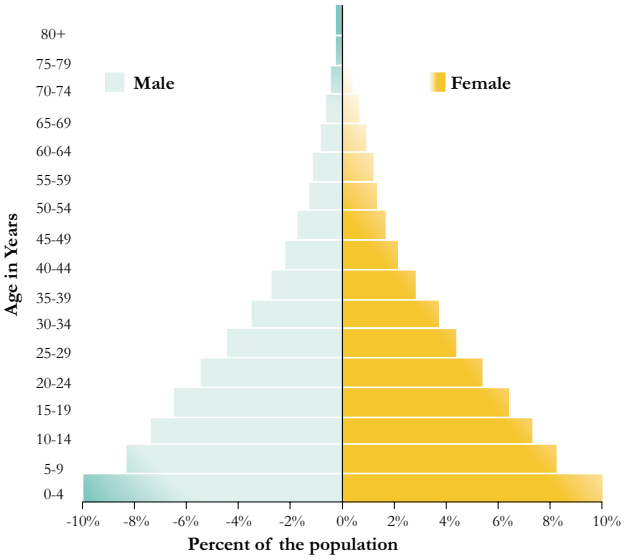
Considerations and assumptions used for projecting resource requirements:

The nation's demographic profile affects the ever-increasing need for resources for FP and hence is taken into consideration to determine the resource requirements for the NFPCIP. Below are the considerations and assumptions used for the NFPCIP to affect CPR projections and determine the resources needed to meet the One Plan target of 60 percent CPR by 2015, assuming a growth rate in CPR of five percentage points each year during 2010–2015. (Appendix D provides a definition of the terms used in the NFPCIP and in the analysis):

(a) Annual Growth in CPR

The analysis that projects CPR and method-mix targets for the NFPCIP is based on data from the most recent DHS for Tanzania, conducted in 2004–2005. To bring the CPR estimate to 2009, the growth in CPR has been assumed to remained constant at 0.6 percentage points annually since the last DHS, because that was the rate of growth in CPR between 1999 and 2004–2005. A new DHS is currently ongoing until late 2010. Findings from the new survey may show this assumption to be incorrect because of the loss in momentum in the FP program discussed in the Introduction and the recent and continuing stock-outs of contraceptives discussed in the Issues and Challenges section. If the growth in CPR is lower than has been assumed, the challenges of meeting the One Plan targets will be even greater.

Figure 1. Polpulation Pyramid for Tanzania

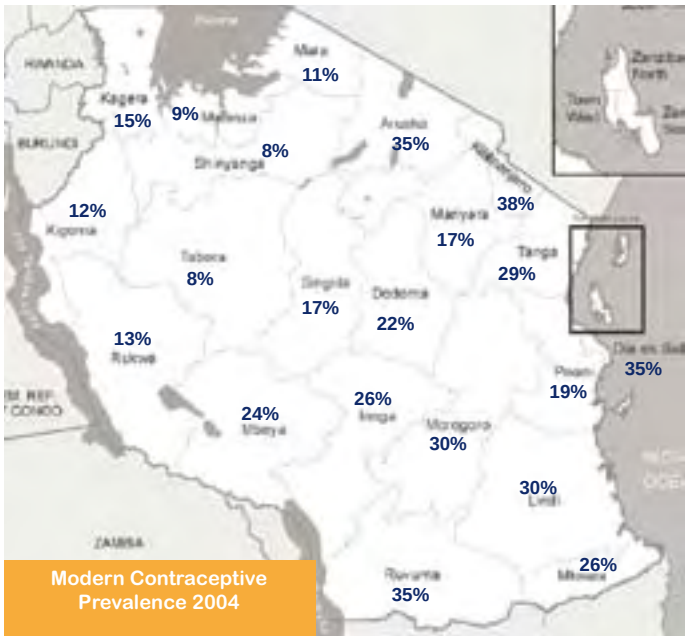


An important factor in these projections is that the total number of women of reproductive age (WRA) expands each year. This is because of the age structure of Tanzania's population (the Population Pyramid). As shown in Table 1 (see Introduction), 47 percent of the population was under 15 years of age in 2004–2005. All of the girls who will reach reproductive age between now and 2015 have already been born, and each year an ever-increasing number of girls will reach reproductive age. A number of women will also 'age out' of reproductive age each year, but because of the population pyramid (Figure 1), that number will always be smaller than the number of girls entering reproductive age. This growing denominator further stresses the FP program to deliver more services to achieve the 60 percent CPR goal by 2015. Assuming a CPR of 28 percent in 2008, there are 2.02 million current users of all methods of FP. To reach the One Plan target, taking into account the growing denominator, the number of FP users must more than double, to a total of 5.23 million users by 2015.

(b) Regional Variations in CPR

The map in Figure 2 shows the wide regional variations in CPR at the time of the last DHS. CPR for all methods ranged from a low of 10.3 percent in Tabora region to a high of 49.5 percent in Kilimanjaro region. Two thirds of the regions had a CPR of less than 40 percent. A number of factors influence this variation in CPR, including availability of infrastructure and skilled providers, social and cultural norms, and the relative level of priority given to FP by communities and local governments. These factors, as well as the starting point of current CPR, will all influence whether and how quickly each region can increase its CPR and contribute toward meeting the One Plan target.

Figure 2. Modern Contraceptive Prevalence by Region, 2005–2005



Source: TDHS 2004

(c) Regional Variations in Method Mix

Table 3 shows that the mix of FP methods also varied by region at the time of the 2004–2005 DHS. The Kilimanjaro region, with relatively stronger infrastructure and more highly trained providers, for example, had the highest rates of use for LAPMs, whereas pills and condoms were more likely to make up the majority of the method mix in regions with less well-equipped facilities and less-skilled staff. It also shows the relatively high demand for injectables and the very low use of IUDs.

Table 3. Contraceptive Method Mix by Region, DHS 2004–2005

Region	% Total Population	Female Sterilization	Pill	IUD	Injectables	Implant	Condom	LAPM
Kilimanjaro	0.062	10.2	6.8	1	17.2	1.6	1.5	0
Arusha	0.035	1.8	11.2	0.8	15.5	0.8	3	1.6
Mbeya	0.066	2	7	0	9.2	1	2.2	2
Dar es Salaam	0.07	3.7	11.6	0.9	13.7	1.5	3.4	0
Ruvuma	0.036	6.1	7.7	0	14.5	1.3	5.2	0
Tanga	0.053	1.8	6.3	0.5	15.5	0.9	4	0
Iringa	0.052	3.4	7.8	0	10.4	0	4.4	0.5
Morogoro	0.054	4.5	10.6	0	11.2	0.5	2.6	0.6
Lindi	0.026	3.5	18.3	0	6.1	0.4	1.8	0
Mtwara	0.034	2.2	13.6	0	9.2	0	0.9	0
Manyara	0.029	0.9	3.9	0	5.9	0	1.4	5.2
Dodoma	0.052	1	9.5	0	9.8	0	2	0
Coast (Pwani)	0.026	1.4	4.4	0	9.6	1.6	2.3	0
Kigoma	0.037	2.5	1.4	0.3	5.8	0	0.6	1
Singida	0.033	2.3	6.1	0.3	7.6	0	0.6	0
Rukwa	0.034	0.3	3.5	0.5	5.1	0	3.6	0
Kagera	0.059	3.4	3	0	7.5	0	1.1	0
Mara	0.042	1.8	1.1	0	6.7	0.3	0.6	0.3
Mwanza	0.08	2.2	2.2	0	3.2	0.3	0.6	0.7
Shinyanga	0.078	1.9	1.9	0	2.1	0.2	1.5	0
Tabora	0.043	1.2	0.5	0	4.5	0.3	1.3	0

Projecting Population Growth and Needs for FP

(a) Regional Stratification of CPR and Total Demand to Reach One Plan Target

Table 4 shows the projected total population for Tanzania in 2004 at 36 million, and the numbers and percentages of the population residing in each region. It also shows the CPR, all methods, and the total demand (CPR plus unmet need) in each region at the time of the DHS (2004–2005), with an overall CPR of 28 percent. This table groups the regions into five strata based on the CPR. For each stratum, it shows at the time of the last DHS the relative contribution that each stratum made toward achieving a national CPR of 60 percent. The table also shows the stratum-specific CPR that must be reached by 2015 to achieve the One Plan target. For example, Stratum 1 shows Kilimanjaro and Arusha having the highest CPRs in 2004–2005. These two regions account for 9.7 percent of Tanzania's total population. For the country to reach 60 percent CPR overall, the regions in Stratum 1 will need to reach a CPR of 72 percent by 2015. The stratum with the lowest CPR, and with almost a quarter of Tanzania's population, will need to increase its CPR from around 11 percent in 2004–2005 to 49 percent by 2015 for the country to reach its One Plan target. All regions will need to increase demand to reach their targets, but meeting the current total demand in each region would make a significant contribution to reaching the targets.

Table 4. Population, CPR (2004–2005), and Total Demand with Regional Stratification and CPR Targets to Reach One Plan Target

Region	2004–2005 DHS				Stratum Analysis		
	Projected population	CPR, all methods	Total demand	% Total Population	2015 CPR Target	% Total Population	Relative Contribution
Kilimanjaro	2,228,526	49.50%	69.60%	6.20%	72.00%	9.70%	0.07
Arusha	1,247,982	48.60%	65.50%	3.50%			
Mbeya	2,369,368	45.10%	57.50%	6.60%	68.00%	22.50%	0.153
Dar es Salaam	2,522,531	44.60%	59.60%	7.00%			
Ruvuma	1,280,113	41.60%	59.60%	3.60%			
Tanga	1,922,318	40.20%	60.60%	5.30%			
Iringa	1,871,754	35.10%	54.80%	5.20%			
Morogoro	1,928,864	34.60%	50.20%	5.40%			
Lindi	939,928	33.50%	55.20%	2.60%			
Mtwara	1,225,136	26.80%	51.30%	3.40%	62.00%	27.20%	0.169
Manyara	1,041,894	26.50%	54.50%	2.90%			
Dodoma	1,861,085	23.80%	52.20%	5.20%			
Coast (Pwani)	935,906	22.20%	46.80%	2.60%			
Kigoma	1,331,265	19.80%	52.80%	3.70%	55.00%	16.30%	0.09
Singida	1,204,090	18.30%	43.50%	3.30%			
Rukwa	1,231,549	18.10%	35.50%	3.40%			
Kagera	2,108,853	15.70%	38.80%	5.90%			
Mara	1,530,609	13.00%	42.40%	4.20%	49.00%	24.30%	0.119
Mwanza	2,882,978	11.00%	38.90%	8.00%			
Shinyanga	2,794,746	10.90%	42.60%	7.80%			
Tabora	1,561,744	10.30%	34.80%	4.30%			
Total	**36,021,239**	**28.10%**				**Total CPR**	**60.00%**

(b) Annual CPR Targets, by Region

Table 5 shows the annual CPR, all methods, that each region will need to reach to achieve the One Plan target of 60 percent CPR by 2015. It assumes a 0.6 percentage point growth in CPR each year since the last DHS. These projections serve as the basis for estimating the commodities and other inputs that will be required to deliver the projected volume and mix of FP services. Although not all of the regions will reach the One Plan target by 2015, the nation as a whole would meet the 60 percent target at this growth rate in CPR. In all, 13 regions will meet or exceed 60 percent CPR at this rate of growth; the remainder will achieve lower CPRs.

Table 5. Growth in CPR, Assuming a 0.6 percent Increase from 2004 to 2009 and Reaching National Target in 2015

	2004–2005 DHS		PROJECTIONS										
Region	CPR all method	% Total Population	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Kilimanjaro	49.50%	6.20%	50%	51%	51%	52%	53%	56%	59%	62%	66%	69%	**72%**
Arusha	48.60%	3.50%	49%	50%	50%	51%	52%	55%	58%	62%	65%	69%	**72%**
Mbeya	45.10%	6.60%	46%	46%	47%	48%	48%	51%	55%	58%	61%	65%	**68%**
Dar es Salaam	44.60%	7.00%	45%	46%	46%	47%	48%	51%	54%	58%	61%	65%	**68%**
Ruvuma	41.60%	3.60%	42%	43%	43%	44%	45%	49%	52%	56%	60%	64%	**68%**
Tanga	40.20%	5.30%	41%	41%	42%	43%	43%	47%	51%	56%	60%	64%	**68%**
Iringa	35.10%	5.20%	36%	36%	37%	38%	38%	42%	46%	50%	54%	58%	**62%**
Morogoro	34.60%	5.40%	35%	36%	36%	37%	38%	42%	46%	50%	54%	58%	**62%**
Lindi	33.50%	2.60%	34%	35%	35%	36%	37%	41%	45%	49%	54%	58%	**62%**
Mtwara	26.80%	3.40%	27%	28%	29%	29%	30%	35%	41%	46%	51%	57%	**62%**
Manyara	26.50%	2.90%	27%	28%	28%	29%	30%	35%	40%	46%	51%	57%	**62%**
Dodoma	23.80%	5.20%	24%	25%	26%	26%	27%	33%	39%	44%	50%	56%	**62%**
Coast (Pwani)	22.20%	2.60%	23%	23%	24%	25%	25%	31%	37%	44%	50%	56%	**62%**
Kigoma	19.80%	3.70%	20%	21%	22%	22%	23%	28%	34%	39%	44%	50%	**55%**
Singida	18.30%	3.30%	19%	20%	20%	21%	21%	27%	33%	38%	44%	49%	**55%**
Rukwa	18.10%	3.40%	19%	19%	20%	21%	21%	27%	32%	38%	44%	49%	**55%**
Kagera	15.70%	5.90%	16%	17%	18%	18%	19%	25%	31%	37%	43%	49%	**55%**
Mara	13.00%	4.20%	14%	14%	15%	15%	16%	22%	27%	33%	38%	44%	**49%**
Mwanza	11.00%	8.00%	12%	12%	13%	13%	14%	20%	26%	32%	37%	43%	**49%**
Shinyanga	10.90%	7.80%	12%	12%	13%	13%	14%	20%	26%	31%	37%	43%	**49%**
Tabora	10.30%	4.30%	11%	12%	12%	13%	13%	19%	25%	31%	37%	43%	**49%**
National	**28.1%**		**28.7**	**29.3**	**29.9**	**30.5**	**31.1**	**35.9**	**40.7**	**45.6**	**50.4**	**55.2**	**60**

(c) Method Mix Targets by 2015

The next table, Table 6, sets the method-mix targets to be achieved in each region by 2015 to meet the One Plan target. The analysis in this table, an important step in estimating the volume of contraceptive commodities that must be available each year, is based on the use of each method reported in the last DHS and on recent expansion in availability and demand for some methods. The targets are shown are the percentage levels that each method is expected to reach in each region, totalling to 100 percent in each region. The projections in this table take into account a variety of contextual factors, including sociocultural considerations, availability of infrastructure, and provider capacity, that are likely to influence provision and acceptance of each method. These targets also take into consideration the recommendations of the National Family Planning Working Group to shift use, wherever feasible, from less effective to more effective methods while maintaining the widest possible range of method choices. For example, targets assume a shift of some users from traditional to modern methods. Within temporary methods, some users are shifted from those methods requiring high levels of personal adherence (pills and condoms) to injectables. An overall shift to LAPMs is also assumed, especially in regions with better infrastructure and more highly skilled providers.

Table 6. Contraceptive Method-Mix Targets, 2015, by Region, Based on Contextual Factors

Region	Female Sterilization	Pills	IUD	Injectables	Implant	Condoms	Traditional
Kilimanjaro	16.0%	7.0%	9.0%	50.0%	10.0%	3.0%	5.0%
Arusha	3.0%	18.0%	3.0%	50.0%	9.0%	7.0%	10.0%
Mbeya	3.6%	14.0%	2.4%	34.0%	6.0%	5.0%	35.0%
Dar es Salaam	6.0%	22.0%	4.0%	40.0%	15.0%	8.0%	5.0%
Ruvuma	10.0%	14.0%	2.5%	40.0%	12.5%	13.0%	8.0%
Tanga	3.0%	23.0%	2.4%	45.0%	6.6%	10.0%	10.0%
Iringa	6.3%	25.0%	2.4%	35.0%	3.3%	13.0%	15.0%
Morogoro	8.5%	22.0%	3.0%	45.0%	8.5%	8.0%	5.0%
Lindi	6.6%	37.0%	3.6%	35.0%	7.8%	6.0%	4.0%
Mtwara	4.3%	40.0%	2.4%	45.0%	5.3%	3.0%	0.0%
Manyara	2.0%	30.0%	1.2%	30.0%	2.8%	6.0%	28.0%
Dodoma	2.2%	20.0%	1.6%	60.0%	4.2%	8.0%	4.0%
Coast (Pwani)	4.0%	10.0%	4.0%	55.0%	12.0%	10.0%	5.0%
Kigoma	5.7%	9.0%	4.0%	38.0%	10.3%	3.0%	30.0%
Singida	5.2%	15.0%	4.0%	60.0%	10.8%	3.0%	2.0%
Rukwa	2.3%	22.0%	1.4%	35.0%	3.0%	21.0%	15.3%
Kagera	7.8%	8.0%	6.0%	53.0%	16.2%	7.0%	2.0%
Mara	4.7%	5.0%	4.0%	60.0%	11.3%	5.0%	10.0%
Mwanza	6.5%	20.0%	6.0%	40.0%	17.5%	6.0%	4.0%
Shinyanga	6.0%	16.0%	6.0%	30.0%	18.0%	16.0%	8.0%
Tabora	4.0%	5.0%	4.0%	56.0%	12.0%	14.0%	5.0%
National	**5.9%**	**17.5%**	**4.0%**	**44.0%**	**10.4%**	**8.4%**	**9.8%**

(d) Annual Method-Mix Growth to reach One Plan target

Based on the method-mix targets in Table 6, Table 7 projects the annual rate of growth in each method that will be required in all regions, starting in 2010 and reaching the One Plan target of 60 percent CPR by 2015. This table is used to project the absolute volume of commodities that will be required each year to achieve the One Plan target.

Table 7. Annual Rate of Growth by Contraceptive Method, by Region, 2010–2015, to Achieve One Plan CPR Target

Method mix targets @ 60% CPR in 2015

Region			2010							2011								2012								2013								2014								2015			
	% Pop	Yrs to target	Fster	Pill	IUD	Inject	Implant	Cond	Trad	Fster	Pill	IUD	Inject	Implant	Cond	Trad	Fster	Pill	IUD	Inject	Implant	Cond	Trad	Fster	Pill	IUD	Inject	Implant	Cond	Trad	Fster	Pill	IUD	Inject	Implant	Cond	Trad	Fster	Pill	IUD	Inject	Implant	Cond	Trad
Kilimanjaro	0.062	6	0.11	0.07	0.02	0.22	0.03	0.02	0.10	0.11	0.07	0.03	0.25	0.04	0.02	0.08	0.11	0.06	0.04	0.27	0.04	0.02	0.07	0.11	0.06	0.05	0.30	0.05	0.02	0.06	0.11	0.05	0.06	0.33	0.06	0.02	0.05	0.12	0.05	0.06	0.36	0.07	0.02	0.04
Arusha	0.035	6	0.02	0.13	0.01	0.22	0.02	0.04	0.11	0.02	0.13	0.01	0.24	0.03	0.04	0.10	0.02	0.13	0.02	0.27	0.04	0.04	0.10	0.02	0.13	0.02	0.30	0.05	0.05	0.09	0.02	0.13	0.02	0.33	0.06	0.05	0.08	0.02	0.13	0.02	0.36	0.06	0.05	0.07
Mbeya	0.066	6	0.02	0.09	0.00	0.13	0.02	0.03	0.23	0.02	0.09	0.01	0.15	0.02	0.03	0.23	0.02	0.09	0.01	0.17	0.03	0.03	0.23	0.02	0.09	0.01	0.19	0.03	0.03	0.23	0.02	0.09	0.01	0.21	0.04	0.03	0.24	0.02	0.10	0.02	0.23	0.04	0.03	0.24
Dar es Salaam	0.070	6	0.04	0.13	0.01	0.17	0.03	0.04	0.09	0.04	0.13	0.02	0.19	0.04	0.04	0.08	0.04	0.14	0.02	0.21	0.06	0.05	0.07	0.04	0.14	0.02	0.23	0.07	0.05	0.06	0.04	0.15	0.02	0.25	0.09	0.05	0.05	0.04	0.15	0.03	0.27	0.10	0.05	0.03
Ruvuma	0.036	6	0.07	0.09	0.00	0.18	0.03	0.06	0.07	0.07	0.09	0.01	0.20	0.04	0.07	0.06	0.07	0.09	0.01	0.21	0.05	0.07	0.06	0.07	0.09	0.01	0.23	0.06	0.08	0.06	0.07	0.09	0.01	0.25	0.07	0.08	0.06	0.07	0.10	0.02	0.27	0.09	0.09	0.05
Tanga	0.053	6	0.02	0.08	0.01	0.19	0.02	0.05	0.11	0.02	0.10	0.01	0.21	0.02	0.05	0.10	0.02	0.11	0.01	0.24	0.03	0.06	0.09	0.02	0.13	0.01	0.26	0.03	0.06	0.09	0.02	0.14	0.01	0.28	0.04	0.06	0.08	0.02	0.16	0.02	0.31	0.04	0.07	0.07
Iringa	0.052	6	0.04	0.10	0.00	0.13	0.00	0.05	0.10	0.04	0.11	0.01	0.15	0.01	0.06	0.09	0.04	0.12	0.01	0.17	0.01	0.06	0.09	0.04	0.13	0.01	0.18	0.01	0.07	0.09	0.04	0.14	0.01	0.20	0.02	0.08	0.09	0.04	0.16	0.01	0.22	0.02	0.08	0.09
Morogoro	0.054	6	0.05	0.12	0.00	0.15	0.01	0.03	0.04	0.05	0.13	0.01	0.18	0.02	0.04	0.04	0.05	0.13	0.01	0.20	0.03	0.04	0.04	0.05	0.13	0.01	0.23	0.04	0.04	0.03	0.05	0.13	0.02	0.25	0.04	0.05	0.03	0.05	0.14	0.02	0.28	0.05	0.05	0.03
Lindi	0.026	6	0.04	0.22	0.00	0.10	0.01	0.02	0.02	0.04	0.22	0.01	0.12	0.02	0.03	0.02	0.04	0.22	0.01	0.14	0.03	0.03	0.02	0.04	0.22	0.01	0.17	0.03	0.03	0.02	0.04	0.23	0.02	0.19	0.04	0.03	0.02	0.04	0.23	0.02	0.22	0.05	0.04	0.02
Mtwara	0.034	6	0.03	0.17	0.00	0.13	0.01	0.01	0.00	0.03	0.19	0.01	0.16	0.01	0.01	0.00	0.03	0.20	0.01	0.19	0.02	0.01	0.00	0.03	0.22	0.01	0.22	0.02	0.02	0.00	0.03	0.23	0.01	0.25	0.03	0.02	0.00	0.03	0.25	0.01	0.28	0.03	0.02	0.00
Manyara	0.029	6	0.01	0.07	0.00	0.09	0.00	0.02	0.15	0.01	0.09	0.00	0.11	0.01	0.02	0.16	0.01	0.12	0.00	0.13	0.01	0.03	0.16	0.01	0.14	0.01	0.15	0.01	0.03	0.16	0.01	0.16	0.01	0.17	0.01	0.03	0.17	0.01	0.19	0.01	0.19	0.02	0.04	0.17
Dodoma	0.052	6	0.01	0.11	0.00	0.15	0.00	0.03	0.02	0.01	0.11	0.00	0.20	0.01	0.03	0.02	0.01	0.12	0.01	0.24	0.01	0.04	0.02	0.01	0.12	0.01	0.28	0.02	0.04	0.02	0.01	0.12	0.01	0.33	0.02	0.05	0.02	0.01	0.12	0.01	0.37	0.03	0.05	0.02
Coast (Pwani)	0.026	6	0.02	0.05	0.00	0.15	0.03	0.03	0.03	0.02	0.05	0.01	0.19	0.04	0.04	0.03	0.02	0.06	0.01	0.22	0.05	0.04	0.03	0.02	0.06	0.02	0.26	0.06	0.05	0.03	0.02	0.06	0.02	0.30	0.07	0.06	0.03	0.02	0.06	0.02	0.34	0.07	0.06	0.03
Kigoma	0.037	6	0.03	0.02	0.01	0.09	0.01	0.01	0.11	0.03	0.03	0.01	0.12	0.02	0.01	0.12	0.03	0.03	0.01	0.14	0.03	0.01	0.13	0.03	0.04	0.02	0.16	0.04	0.01	0.14	0.03	0.04	0.02	0.19	0.05	0.01	0.15	0.03	0.05	0.02	0.21	0.06	0.02	0.17
Singida	0.033	6	0.03	0.08	0.01	0.13	0.01	0.01	0.01	0.03	0.08	0.01	0.17	0.02	0.01	0.01	0.03	0.08	0.01	0.21	0.03	0.01	0.01	0.03	0.08	0.02	0.25	0.04	0.01	0.01	0.03	0.08	0.02	0.29	0.05	0.01	0.01	0.03	0.08	0.02	0.33	0.06	0.02	0.01
Rukwa	0.034	6	0.01	0.06	0.01	0.08	0.00	0.06	0.06	0.01	0.07	0.01	0.11	0.01	0.07	0.06	0.01	0.08	0.01	0.13	0.01	0.08	0.07	0.01	0.09	0.01	0.15	0.01	0.09	0.07	0.01	0.11	0.01	0.17	0.01	0.10	0.08	0.01	0.12	0.01	0.19	0.02	0.12	0.08
Kagera	0.059	6	0.04	0.04	0.01	0.12	0.01	0.02	0.01	0.04	0.04	0.01	0.16	0.03	0.02	0.01	0.04	0.04	0.02	0.19	0.04	0.03	0.01	0.04	0.04	0.02	0.22	0.06	0.03	0.01	0.04	0.04	0.03	0.26	0.07	0.03	0.01	0.04	0.04	0.03	0.29	0.09	0.04	0.01
Mara	0.042	6	0.02	0.02	0.00	0.12	0.01	0.01	0.03	0.02	0.02	0.01	0.15	0.02	0.01	0.04	0.02	0.02	0.01	0.19	0.03	0.02	0.04	0.02	0.02	0.01	0.22	0.04	0.02	0.04	0.02	0.02	0.02	0.26	0.05	0.02	0.05	0.02	0.02	0.02	0.29	0.06	0.02	0.05
Mwanza	0.080	6	0.03	0.04	0.01	0.07	0.02	0.01	0.02	0.03	0.05	0.01	0.10	0.03	0.02	0.02	0.03	0.06	0.01	0.12	0.05	0.02	0.02	0.03	0.08	0.02	0.15	0.06	0.02	0.02	0.03	0.09	0.02	0.17	0.07	0.03	0.02	0.03	0.10	0.03	0.20	0.09	0.03	0.02
Shinyanga	0.078	6	0.03	0.04	0.01	0.05	0.02	0.03	0.03	0.03	0.05	0.01	0.07	0.03	0.04	0.03	0.03	0.05	0.01	0.09	0.05	0.05	0.03	0.03	0.06	0.02	0.11	0.06	0.06	0.03	0.03	0.07	0.02	0.13	0.07	0.07	0.04	0.03	0.08	0.03	0.15	0.09	0.08	0.04
Tabora	0.043	6	0.02	0.01	0.00	0.10	0.01	0.03	0.02	0.02	0.01	0.01	0.13	0.02	0.04	0.02	0.02	0.02	0.01	0.17	0.03	0.04	0.02	0.02	0.02	0.01	0.20	0.04	0.05	0.02	0.02	0.02	0.02	0.24	0.05	0.06	0.02	0.02	0.02	0.02	0.27	0.06	0.07	0.02
National			0.03	0.08	0.01	0.13	0.02	0.03	0.07	0.03	0.08	0.01	0.16	0.02	0.03	0.06	0.04	0.09	0.01	0.18	0.03	0.04	0.06	0.04	0.10	0.02	0.21	0.04	0.04	0.06	0.04	0.10	0.02	0.24	0.05	0.05	0.06	0.04	0.11	0.02	0.26	0.06	0.05	0.06
Method mix			9.7%	21.8%	1.7%	36.5%	4.2%	8.0%	18.2%	8.6%	20.6%	2.3%	38.7%	6.0%	8.1%	15.8%	7.7%	19.7%	2.8%	40.4%	7.3%	8.1%	13.9%	7.1%	18.9%	3.3%	41.8%	8.4%	8.2%	12.4%	6.5%	18.3%	3.6%	43.0%	9.3%	8.2%	11.1%	6.0%	17.8%	3.9%	43.9%	10.1%	8.2%	10.1%

Fster: Female Sterilization

Inject: Injectables

Cond: Condoms

Trad: Traditional methods

Strategic Actions to Achieve Objectives

Tanzania's FP program must be revitalized to achieve an annual growth rate in CPR of 5 percentage points or to even return to a growth rate of 1.5 percentage points. The NFPCIP has five SAAs to revitalize and reposition FP to obtain an overall increase in CPR consistent with the One Plan target of 60%. Each SAA has a set of strategic actions that are broken down into the various activities or steps needed for implementation, and the activities are further specified with required inputs that form the basis for estimating the cost. The strategic actions and activities address the issues and challenges discussed previously to ensure that FP considerations and resources are integrated with other ongoing health sector strategic programs, such as the HSSPIII, PHSDP, and HRHSP. As noted elsewhere, the activities and their costs included here are aimed specifically at what is needed to address, elevate, and include FP as a coequal program along with other health sector program initiatives. These costs therefore do not duplicate investments in other strategic health programs. Cost estimates for implementing activities at the District level have not been included in the NFPCIP. These have been included in a complementary document to guide District planners to budget essential interventions that will contribute to the NFPCIP targets and thus should be included in the CCHPs. Furthermore, the government contributions to the NFPCIP, including salaries for human resources and infrastructure (equipment, furniture, supplies, electricity, and water supplies), can range from 40 to 60 percent of the total budgetary estimates. These estimates have not been included in the NFPCIP.

The following tables describe the activities for each SAA, and the timeframe and process for implementation are indicated. A detailed breakdown of factors is shown as the basis for estimating the costs for each activity. Finally, the success indicator for monitoring Plan implementation is shown for each SAA. More detail for each SAA is provided in Appendix E.

Given the need to fulfil increasing demand for FP services in the country, two areas have been identified as the key priorities for implementation and funding of the NFPCIP: ensuring contraceptive security and enhancing service delivery and capacity building, in particular, strengthening integrated service delivery of FP in all aspects of the health sector, including HIV/AIDS, immunization services, PNC, and PAC. As such, contraceptive commodities represent 91 percent of the total NFPCIP budget. In the beginning stages, focus will be on meeting demand; in subsequent years, efforts will be enhanced to generate and sustain demand for FP to meet the One Plan target.

Strategic Action Area I: Contraceptive Security

This SAA refers to expanded availability and choices of safe, effective, acceptable and affordable **contraceptive methods**. It addresses contraceptive logistics and security, ensuring that supplies of all contraceptive commodities are adequate to meet the needs and preferences of family planning clients.

Based on the method-mix targets to be achieved in each region by 2015 to meet the One Plan target (see Table 7), the number of users to be reached is an estimated 5.23 million WRA at an annual cost ranging from Tshs 16 billion in FY 2010–2011 to 25 billion in FY 2015–2016.

STRATEGIC ACTIVITIES	TIMEFRAME	SUCCESS INDICATOR	COST (FY 2010–2016)
Strategic Action 1. Ensure adequate supply of contraceptive methods at all levels			
1(a) Ensure sufficient donor and MoFEA funds to cover all public-sector contraceptive commodity needs	Years 1–6	Funding requests match resource needs	119,997,745,046
1(b) Establish a forum of regular monthly meetings with MSD, RCHS, PSU, World Bank, and Supplies Unit to discuss status of ongoing procurement, identify bottlenecks, and stock situation countrywide and by zone	Year 1	# meetings held; evidence that issues identified are dealt with before next meeting	54,952,500
1(c) Streamline forecasting, procurement, distribution, use monitoring, and reporting	Year 1	Increased budget allocation for contraceptives; reduced stock-outs	81,940,500
1(d) Develop an automated system to capture facility-level logistics data and make available to district, regional, and central decision makers (may involve use of cellphone technology)	Year 1: develop Years 2–6: implement	Increased availability of accurate data	1,005,226,000
1(e) Conduct supportive supervisions to MSD HQ, Zonal MSD, and health facilities for contraceptive commodities (4 supervisions per quarter); supervisory team to include 2 RCHS, 1 Zonal RCHCO, 1 RCHCO, and DRCHCO	Years 1–2: register Years 3–6: distribute	Reduce % unmet needs; increase CPR	189,360,000
Contraceptive Security Total (in Tshs):			**121,329,224,046**

DRCHCo = district reproductive and child health coordinator; MSD = Medical Stores Department; PSU = Program Support Unit; RCHCo = district reproductive and child health coordinator; RCHS = Reproductive and Child Health Section.

Strategic Action Area II: Capacity Building

This SAA refers to **capacity building** of providers to deliver and support the safe, effective use of FP methods and services. It addresses the capacity of the people who deliver FP services. Capacity-building considerations include the numbers, categories, attitudes, skills, supervision, and remuneration of service personnel at all levels and in all sectors.

STRATEGIC ACTIVITIES	TIMEFRAME	SUCCESS INDICATOR	COST (FY 2010–2016)
Strategic Action 1. Increase availability and improve distribution of FP service providers			
1(a) Develop, implement computerized inventory of staff by facility to identify gaps and ensure equitable distribution	Years 1–6	On-line facility specific staff inventory available and updated annually	0[1]
Strategic Action 2. Implement task shifting to all levels of the health system			
2(a) Identify opportunities for task shifting by cadre of health services provider for expanded and integrated FP provision	Year 1	Report on potential for task shifting and necessary changes	22,250,500
2(b) Consultations with professional associations and registrars (MAT, TAMA, AGOTA, PAT, pharmacists, lab associates) on how best to implement evidence-based task shifting for FP provision	Year 2	Report on potential for task shifting and necessary changes	14,310,000

STRATEGIC ACTIVITIES	TIMEFRAME	SUCCESS INDICATOR	COST (FY 2010–2016)
2(c) Consult with relevant authorities on recommendations for policy amendments	Year 3	Recommendations developed for task shifting	14,310,000
2(d) Produce and disseminate policy amendments nationwide	Year 3	Policy amendments made	4,225,000
Strategic Action 3. Improve provider capacity to deliver FP services			
3(a) Update national FP training strategy	Year 1	Updated strategy in place	24,288,750
3(b) Identify and update an inventory of national FP trainers	Years 1, 5	Inventory of FP trainers available	200,000
3(c) Print additional copies of the updated FP procedures manual (3,000) and training curricula (500–Module I; 300–Module II; 100–Module III)	Year 2	# materials produced by type	7,950,000
3(d) Disseminate updated FP procedures manual and training curricula	Years 1–2	# trainers oriented with the new manual and curricula	102,060,750
3(e) Update preservice curricula with up-to-date and comprehensive FP content	Years 1–2	Updated pre-service curricula available	32,456,500
3(f) Train 80 tutors per year in pre-service training institutions on FP curricula	Years 2–4	# tutors trained in new curricula	113,048,000
3(g) Review job aids on client-provider interaction. Print 5,000 job aids for client-provider interaction.	Year 1	Final job aid produced	54,876,000
3(h) Disseminate/orient providers on client-provider interaction.	Year 1	# copies of toolkit produced	173,702,500
3(i) Increase the pool of zonal FP trainers	Years 2–4	# trainers produced	316,434,000
3(j) Conduct CTU in-service training using updated curricula and job aids	Years 1–6	# trainings conducted	3,624,672,000
3(k) Conduct training on short- and long-acting methods	Years 1–2	# trainings conducted	483,115,0003
3(l) Conduct training on permanent methods	Years 1–2	# trainings conducted	393,140,0003
Strategic Action 4. Retain retiring and rehire retired health workers			
4(a) Identify retiring and retired health workers, especially those with FP experience, and rehire	Years 1–6	# of retiring and retired health workers retained	0[2]
4(b) Identify training needs and develop training plan for rehired workers	Years 1–6	Training needs documented, training plan developed	0[2]
4(c) Implement training as needed for retired health workers and allocate as needed	Years 1–6	Trainings held, # trainees reached, increased # of SP providing FP services	0[2]
Strategic Action 5. Include non-coercive FP indicators in pay-for-performance initiative			
5(a) Develop noncoercive FP indicator in pay-for-performance initiative	Year 1	Report on-job satisfaction survey	0
5(b) Ensure inclusion of FP indicator in the benefits package	Years 2–6	Benefit package system established/reviewed	5,617,000
Strategic Action 6. Build capacity for FP advocacy at regional and district levels			
2a) Develop training curriculum for building FP advocacy capacities at regional and district levels	Year 2	Advocacy capacity building strategy in place	212,204,283

STRATEGIC ACTIVITIES	TIMEFRAME	SUCCESS INDICATOR	COST (FY 2010–2016)
2b) Orient representatives from regional and district councils on FP advocacy	Years 2–4	Advocacy activities led by district council RH workers and local FP stakeholders	84,818,000
Capacity Building Total (in Tshs):			*5,683,678,283*

[1]Addressed in HRHSP 2008–2013, strategic objective 4: To improve Workforce Management and Utilization.
[2]Addressed in PHSDP 2007–2017 under the objective Human Resources for Health.
[3]Activity included in the central budget for the first two years to allow districts to incorporate CCHPs in future years. Resources for this activity in the future will be mobilized through CCHPs.
AGOTA = Association of Gynaecologists and Obstetricians of Tanzania; CCHPs = Council Comprehensive Health Plans; CTU = contraceptive technology update; MAT = Medical Association of Tanzania; PAT = Paediatric Association of Tanzania; TAMA = Tanzania Midwives Association.

Strategic Action Area III: Service Delivery

This SAA refers to strengthened **service delivery systems** and increased options for delivery of quality, affordable, and sustainable FP.

Service delivery systems are the organizational components that affect access to family planning services. They include facility- or clinic-based services, CBS, and other modalities and channels within and outside of the health sector. Service delivery systems include physical infrastructure, equipment, and supplies, as well as special considerations and opportunities, such as integration of services, to meet the needs of vulnerable populations such as youth, men, women receiving PNC or PAC, or HIV-infected women.

STRATEGIC ACTIVITIES	TIMEFRAME	SUCCESS INDICATOR	COST (FY 2010–2016)
Strategic Action 1. Strengthen systems, facilities, infrastructure to support FP services at appropriate levels			
1(a) Ensure availability of equipment, infrastructure, and supplies for FP provision (coordination meetings of RCHS with PHSDP, RHMT, CHMT, and implementation partners to improve FP services)	Years 1–6	# of facilities improved	0[1]
1(b) Training on use and maintenance of equipment and physical structure and systems	Year 1	Training completed	0[1]
1(c) Incorporate plans for health facility improvement in annual operating plans	Years 1–6	Funds allocated for facility improvement	0[1]
Strategic Action 2. Foster cost-effective integration and referral of FP with HIV, ANC, PNC, and PAC services for men, women, and youth			
2(a) Develop, implement operational tools for cost-effective integration and referral of FP with HIV, ANC, PNC, PAC services for men, women, youth	Year 1	Supporting documents aligned and ready for use	96,770,000
2(b) Orient RHMTs and CHMTs on operational tools in zonal dissemination meetings	Years 2, 5	Meetings held, materials distributed	55,770,000
2(c) Produce 20,000 copies of logo for branding of SDPs providing services	Years 1, 3	# logos produced	20,000,000

STRATEGIC ACTIVITIES	TIMEFRAME	SUCCESS INDICATOR	COST (FY 2010–2016)
2(d) Brand all public and private SDPs providing FP services with Green Star Logo	Years 1, 3	# branded SDPs	5,000,000
Strategic Action 3. Strengthen and increase availability of integrated CBS			
3(a) Print additional copies of existing CBD guidelines, training curricula, and job aids	Year 1	# copies produced	17,500,000
3(b) Update guidelines, training curriculum, job aids, etc. for CBD	Years 3–4	Updated support materials for CBDs	150,540,000
3(d) Conduct TOTs on guidelines, training curriculum, job aids, etc for CBD	Years 2, 4	# trained CBD trainers in each zone	325,215,000
3(e) Training of CBD supervisors	Years 2–3	# trained CBD supervisors per district	328,324,000
3(f) Explore opportunities to increase access to quality provision of injectables in the community	Year 3	# completed studies with findings implemented	270,000,000
3(g) Supportive supervision from the central level (integrated)	Years 1–6	# supervision visits	384,000,000
3(h) Expand methods available through pharmacies, ADDOs, drug shops, social marketing	Years 2–5	# of new access points and sales volumes	32,200,000
3(i) Sensitize RMTs and CMTs on introducing or revitalizing the CBD program	Years 2–3	# of sensitization meetings held	110,190,000
3(j) Conduct training of 1,500 CBD workers per year, including youth workers	Years 1–6	# of CBDs trained	0[2]
Strategic Action 4. Increase awareness and acceptability of FP services by males			
4(a) Conduct situational analysis of male involvement and participation in FP/SRH	Years 1	Situational analysis conducted	60,000,000
4(b) Develop print messages and radio spots to be deployed in all regions	Years 1	# posters radio and TV spots developed	23,567,500
Strategic Action 5. Increase availability of FP-related YFS			
5(a) Update FP trainers on the key strategies on adolescent YFS and peer education	Year 1	# FP trainers trained on the provision of YFS	143,190,000
5(b) Train providers in provision of YFS	Year 2	# providers trained and providing YFS	0[2]
Strategic Action 6. Strengthen, expand FP through private sector (includes NGOs, FBOs, social marketing, commercial sector, private clinics, etc.)			
6(a) Assess capacity, qualifications of a sample of private-sector facilities (FBO, NGO, commercial) to provide FP services according to national standards and guidelines.	Year 1	Assessment conducted	60,000,000
6(b) Build capacity and promote provision of FP services by the private sector, including increasing the number of facilities registered for RCH services	Year 1	Inventory of private sector SDP available; coordination mechanism in place	52,432,500
6(c) Orient CHMTs, zonal training institutions, and APHFTA on the plan and their expected roles to support its implementation	Years 2, 3	# People oriented on role of private sector in FP service provision	95,150,000
6(d) Promote enhanced private sector provision of FP services	Years 2–5	# People oriented on role of private sector in FP service provision	48,607,500

STRATEGIC ACTIVITIES	TIMEFRAME	SUCCESS INDICATOR	COST (FY 2010–2016)
6(f) Explore the feasibility for expanding social marketing of FP products by CBD (formative research study)	Year 1	Study completed; way forward documented	60,000,000
Strategic Action 7. Develop, promote, implement approaches to ensure increased access to FP for low-income and vulnerable groups			
7(a) Conduct segmentation analysis to determine health-seeking attitudes, behaviours, access to FP by economic quintile	Year 1	Report on health-seeking attitudes and behaviours by wealth quintile	2,400,000
7(b) Research access barriers and establish means and approaches to enhance service accessibility among the economically disadvantaged	Year 2	Report on access barriers and recommendations to overcome them	3,360,000
7(c) Develop advocacy strategy to help overcome barriers faced by the economically disadvantaged	Year 3	Changing proportions in service access by wealth quintile	1,200,000
Strategic Action 8. Update/revise and disseminate the FP Provision Policy Guidelines and Standards			
8(a) Revise FP Provision Policy Guidelines and Standards, update supervisory checklist against updated FP standards and guidelines	Year 1	Updated policy guidelines and standards, and supervisory checklist	34,500,283
8(b) Print and distribute 8,000 copies of the policy guidelines	Year 2	# policy guidelines distributed	46,000,000
8(c) Orient DRCHCo, RCHCo, other stakeholders on the updated FP Policy Guidelines and supervisory checklists	Year 2	# of DRCHCos and RCHCos oriented by zone	48,805,000
Service Delivery Total (in Tshs):			*2,213,991,783*

[1]To be conducted in liaison with the PHSDP 2007–2017.

[2]Resources to be mobilized through CCHP.

ADDOs = accredited drug dispensing outlets; ANC = antenatal care; APHFTA = Association of Private Health Facilities in Tanzania; CBD = community-based distribution; CCHP = Council Comprehensive Health Plan; CHMT = Council Health Management Team; CMT = Country Management Team; DRCHCo = reproductive and child health coordinator; PAC = postabortion care; PNC = postnatal care; RCH = reproductive and child health; RCHCo = reproductive and child health coordinator; RHMT = Reproductive Health Management Team; RMT = Regional Management Team; SDP = service delivery point; SRH = sexual and reproductive health; TOT = train the trainer; YFS = youth-friendly services.

Strategic Action Area IV: Advocacy

Reinvigorated **advocacy** increases the visibility of and support for FP as a key investment for improving the lives, health, and well-being of Tanzania's people. This objective addresses the underlying causes of loss of visibility and momentum in the Tanzania FP program as well as the knowledge-use gap among FP clients.

Strategic actions proposed are aimed at sustaining support for FP from the highest policy levels and at promoting public dialogue at all levels, national through community, about the important role of FP in promoting health and gender equity and supporting development. It also involves addressing policies that may impede achievement of the other objectives, such as restrictions on what level of provider is authorized to provide certain contraceptive methods, or how funds for programs are allocated and channelled.

Addressing the knowledge-use gap will involve addressing myths and misinformation about FP and fear of side effects and health concerns that impede its adoption and use. Additionally, it addresses demands for FP that must go beyond maintaining current levels of use and meeting unmet needs if the One Plan target is to be met.

STRATEGIC ACTIVITIES	TIMEFRAME	SUCCESS INDICATOR	COST (FY 2010–2016)
Strategic Action 1. Organize advocacy to prioritize FP with separate budget line for FP			
1(a) Review mechanisms of FP budget-development and resource-allocation systems	Year 1	Report describing budget-development & resource-allocation systems	3,240,000
1(b) Advocacy meetings involving key stakeholders, PMO-RALG, and MoFEA officials leading to establishment of a separate FP budget line item at national, regional, and district levels	Years 1, 2	Budget line established at national, regional, and district levels	10,523,330
Strategic Action 2. Ensure inclusion of FP in major national policy documents, implementation plans that determine budget allocations, stressing significance of FP to national development			
2(a) Conduct a consultation meetings to ensure inclusion of FP in major national policy documents, strategies and plans	Years 1, 3	Report from consultation meeting	6,482,000
Strategic Action 3. Conduct and sustain advocacy targeting development partners and donors to raise level of FP support			
3(a) Mapping of development partners interested in supporting FP	Year 1	Report on local development partners' funding criteria, priorities	20,000,000
3(b) Develop, implement FP resource allocation advocacy strategy targeting development partners	Year 2	Resource allocation from development partners for FP increases	133,690,330
3(c) Organize two 1-day meetings per year involving FP stakeholders on repositioning FP	Years 2–5:	Meetings held and minutes on file indicating action items	29,986,500
Strategic Action 4. Reposition, reinstate Green Star logo as a National FP program			
4(a) Conduct one national relaunch of the Green Star logo by high-level governmental official (include launch materials, e.g., caps, T-shirts, stickers)	Years 1, 2	% of respondents recognizing the logo as a symbol of FP (survey)	161,750,000
Strategic Action 5. Conduct sustained national FP advocacy campaign to provide accurate information, address rumours/misconceptions, promote male involvement, influence social values, and reach vulnerable groups			
5(a) Prepare, produce, broadcast radio spots (52/yr), radio soap opera "Zinduka program" 52 episodes/yr) and TV programs (52 episodes/spots/yr) on FP	Years 1–6	# radio and TV spots produced and aired and estimated listenership	468,000,000
5(b) Produce, distribute revised print materials (posters, IEC, BCC materials) to all clinics and training centres	Years 1–6	Qty of materials produced & distributed by type	1,000,000,000
5(c) Conduct FP campaigns in all ongoing health campaigns and national festivals	Years 1–6	# overall health campaigns adapted to include FP messages	201,300,000
5(d) Revive/orient FP media group to support a multimedia dissemination campaign	Years 1–6	# articles published per year	25,396,750

STRATEGIC ACTIVITIES	TIMEFRAME	SUCCESS INDICATOR	COST (FY 2010–2016)
Strategic Action 6. Establish a network of community-level champions (community leaders, religious leaders, politicians) to reassure the population of the acceptability and benefits of FP			
6(a) Orient DRCHCo and RCHCo about the Champions initiative	Year 1	# oriented on Champions Initiative	123,355,500
6(b) Train zonal trainers on champions approach	Year 1	# Trainers trained to support Champions Initiative	323,980,000
6(c) Support, follow-up districts/regions on the process to identify, select and recruit champions (communication costs only)	Year 1	# Champions recruited	200,000
6(d) Orient recruited champions	Years 1–3	# Champions trained	1,334,850,000
Strategic Action 7. Establish a network of national-level champions to reassure the population of the acceptability and benefits of FP			
7(a) Identify, select, recruit champions via consultations between RCHS and National FP Working Group and other stakeholders	Year 1	# of Champions in place and active	100,000
Advocacy Total (in Tshs):			***3,638,932,250***

BCC = behaviour change communication; DRCHCo = reproductive and child health coordinator; IEC = information, education and communication; MoFEA = Ministry of Finance and Economic Affairs; PMO-RALG = Prime Minister's Office–Regional Administration and Local Government; RCHCo = reproductive and child health coordinator; RCHS = Reproductive and Child Health Section.

Strategic Action Area V: Health Systems Management

Strengthened health systems management and **M&E** of the **national FP program**. This objective addresses the need to reinforce the management capacity at all levels—central, regional, and district council levels. Effective management systems include ensuring that financial resources are made available in a timely manner to all implementing levels, coordinating with other governmental ministries and implementing partners, regular tracking of activities and deliverables needed to achieve plan objectives, integrating with and using the HMIS, and tracking M&E data to improve program performance.

STRATEGIC ACTIVITIES	TIMEFRAME	SUCCESS INDICATOR	COST (FY 2010–2016)
Strategic Action 1. Strengthen leadership and management capacity at RCHS at all levels			
1(a) Organize and conduct a 1-day initial alignment meeting for 60 key persons from national, zonal, regional, and district levels to generate necessary support for the LDP	Year 1	# MoHSW staff who participate, written commitment to support LDP	15,234,750
1(b) Organize and deliver the LDP in three 5-day workshops for six teams of five from central, zonal, and regional level RCH staff	Years 1, 2	# teams formed with action plans	148,663,000
1(c) LDP-trained teams prepare for, present results achieved by implementing action plans in a 2-day meeting for key stakeholders	Year 2 end	# action plans implemented yielding measurable results	26,356,000
1(d) Conduct internal, external study tours to FP providers to learn best practices	Years 1–6	Documented best practices, updated guidelines to support QI	62,304,000

STRATEGIC ACTIVITIES	TIMEFRAME	SUCCESS INDICATOR	COST (FY 2010–2016)
1(e) Support RCHS staff to attend FP courses and national/international meetings	Years 1–6	# of RCHS staff who attended training courses	154,573,800
1(f) Procure a vehicle for RCHS	Year 1	Vehicle procured	270,000,000
Strategic Action 2. Develop, maintain, coordinate, implement an M&E system aligning inputs to outputs at all levels, national through district			
2(a) Conduct rapid assessment of FP services/ data, report to key regional and district staff to guide design of new reporting framework (research assessment, 2-day workshop to share results)	Year 1	Identified gaps in reporting mechanisms and data collection obstacles	30,168,000
2(b) Establish framework, guide, methods for collecting and reporting RCH/FP data at district and regional levels	Year 1	Documented framework for collection and reporting of data on RCH/FP indicators	11,386,250
2(c) Provide training at regional and district levels in strategic planning, using data to set realistic goals, plan and monitor program activities	Years 2–3	Key RCH/FP staff trained in use of data for planning, monitoring performance, developing Annual Action Plans	43,090,000
2(d) Develop, implement executive dashboard to monitor FP program, NFPCIP implementation	Years 2, 3	Using executive dashboard for NFPCIP, FP programs	86,724,250
Strategic Action 3. Strengthen forums on FP to facilitate exchange of information, leverage resources, synchronize activities, and share lessons			
3(a) Conduct monthly National FP Working Group meetings	Years 1–6	# National FP working group meetings held, documented per year	15,120,000
3(b) Revive and maintain RCHS Web site	Years 1–6	Up-to-date FP issues Web site	168,000,000
3(c) RCHS participates in annual coordination meetings with zonal level	Years 2–6	RCHS presence at annual zonal coordination meetings	54,495,000
Strategic Action 4. Establish existing funding levels and applications (public and private sectors) as a basis for resource mobilization			
4(a) Mapping of current FP system - who (public, CSOs, NGOs, FBOs) is doing what, where, when, etc., including National FP Subaccounts; establish and maintain database for FP financing (current and commitments)	Year 1	Report on current structure of FP services, source and use of funds	80,000,000
4(b) Disseminate results of National Family Planning Subaccounts and identify gaps and opportunities for increasing FP financing	Year 1	Reports disseminated	13,935,000
4(c) Disseminate information in ongoing forums at national, regional, and district levels to enable coordination of activities and share lessons learned; engage policy makers, donors	Years 2–6	Functioning cross-sector forum for sharing hosted by RCHS	25,825,000
Health Systems Management Total (in Tshs):			***1,121,230,800***

CSOs = civil society organizations; FBOs: faith-based organizations; LDP = Leadership Development Plan; NGOs = nongovernmental organizations; QI = quality improvement; RCHS = Reproductive and Child Health Section.

Institutional Arrangements for Implementation

The NFPCIP will be implemented under the leadership and management of existing governance structures at all levels of the health system. However, the cooperation, input, and actions from a wide range of partners and stakeholders at all levels are required for success in achieving goals effectively and efficiently. The NFPCIP will be implemented in collaboration with relevant stakeholders, which include related ministries and agencies, development partners, the civil society, community-based organizations (CBOs), professional associations, FBOs, voluntary agencies, and the private sector, among others. The National Family Planning Working Group is expected to continue to play an important role during implementation of the NFPCIP over the next six years. The roles and responsibilities of the many different stakeholders are summarized below.

Ministry of Health and Social Welfare

At the central level, the MoHSW is responsible for overall coordination and oversight of all aspects of the NFPCIP. This includes responsibility for developing or updating policies that affect implementation, for resource mobilization, and for monitoring and evaluation. The NFPCIP will be considered a 'living document': as the monitoring and evaluation of implemented activities provide new information, as changes emerge as a result of the DHS 2009–2010, or as situations evolve, the MoHSW will be responsible for adjusting the Program to incorporate needed changes. Coordination also includes ensuring that the strategic actions and activities of the NFPCIP are integrated and harmonized with and supported by other health-sector programs. Resource mobilization includes the development of annual budgets in collaboration with the MoFEA and in the context of the MTEF. It also involves collaboration with development partners, including those who participate in the sector-wide approach.

Key agencies under the MoHSW also will play crucial roles in implementing the NFPCIP, including MSD and the Tanzania Food and Drug Authority (TFDA). Close coordination and improvements in procurement of contraceptive commodities through the MSD are essential to provide adequate supplies of FP methods for all service delivery partners, in both the public and private sectors. During the next six years, new, improved, or more cost-effective contraceptive technologies may become available, and incorporating such new methods into the program will require review and approval of the TFDA.

A large segment of the NFPCIP is aimed at improving the FP knowledge and skills of health providers. This includes updating and strengthening the FP components of training through public- and private-sector training institutions and the Zonal Training Centres.

Local Government Authorities

Health services, including FP, are the responsibility of the MoHSW and of **LGAs**. Planning and budgeting for health services delivery has been decentralized to the district level, including prioritizing the inclusion of FP in CCHPs. As the LGAs assume greater responsibility for planning, budgeting, and monitoring delivery of services in the communities in their districts, they will similarly play critical roles in achieving the NFPCIP objectives.

The **PMO-RALG** directly supervises the LGAs and, with the MoHSW, reviews and assesses the CCHPs. Reviews pay close attention to ensure the inclusion of FP resources and adequate justification in the CCHPs before they are approved for funding.

The **PMO** itself provides overall government coordination, including the coordination of the government's response to HIV/AIDS. The Tanzania Commission on AIDS (**TACAIDS**) operates under the auspices of the PMO, and it will be instrumental in ensuring the integration of FP as a key strategy for HIV/AIDS prevention.

The **MoFEA** collaborates closely with the MoHSW in budget planning, disbursement of funds, and accounting for expenditures. Improved coordination and communication between the MoFEA and MoHSW will ensure timely disbursement of funds needed for implementation of the NFPCIP.

The **Ministry of Education** is responsible for health cadres with university-level training. As such, this Ministry will be a crucial partner in ensuring the inclusion of evidence-based FP curricula in pre-service training for health personnel in collaboration with the MoHSW.

Development Partners

Included in this category are the bilateral and multilateral donors. Also included in this category is a host of implementing partners that provide technical assistance and expertise in support of the national FP program. Donor agencies will be called upon to increase their support and to augment the resources that will be required for the NFPCIP.

Implementing Partner will continue to be called upon by and under the coordination of the MoHSW for their wide variety of expertise. These reflect all five of the SAAs and will be drawn from experiences in Tanzania and throughout the world to ensure that the implementation of the NFPCIP reflects state-of-the-art information and interventions.

Civil Society Organizations

Although about 80 percent of FP services are provided through the public sector, a number of NGOs and FBOs also play important roles in service delivery. As such, they are critical partners in implementing the NFPCIP. The FBOs are important sources of broader health care, especially in some rural areas of Tanzania, and many of them include FP as components of their services. The MoHSW will continue to look to these partners in implementing the NFPCIP. This includes ensuring coordination and training, procurement of contraceptive commodities, and ensuring adherence to set service standards and guidelines. These organizations are also expected to contribute their service data for M&E, to assist the MoHSW in maintaining a comprehensive picture of NFPCIP implementation, as well as identifying needs and opportunities to expand services.

Resource Mobilization Framework

The level of resources that will be required for successful implementation of the SAAs to reposition FP and achieve the One Plan target for FP will need to expand considerably and quickly. The main sources of funding for the current program include the Tanzanian government; the Basket funds managed through the MTEF, through which most multilateral and bilateral donors currently contribute; and 'out-of-basket' funds from a few donors, most notably the United States Agency for International Development (USAID). Other sources of support include funding from NGOs and FBOs as well as costs recovered through fees for service by private-sector providers.

In implementing the NFPCIP, the MoHSW will provide guidance to ensure that annual budget requests to the MTEF from the district levels include FP, so that Basket funds can be used to support FP. Improving understanding of the budgeting process, as well as increasing the level of priority for FP at the district level are both key recommended implementation actions of the NFPCIP that can help to address this resource mobilization challenge. Recent recommendations from the Tanzania Parliamentary Association for Population and Development call for a larger portion of Basket funds to be spent on FP commodities, and for creating an independent FP budget line item in the budget guidelines. Such actions are currently underway under the leadership of the MoHSW.

Expanding involvement of the private sector, including building on current social-marketing programs, will also be promoted to increase resources for FP. NGOs and FBOs can also play a greater role by mobilizing and allocating resources for implementing the NFPCIP.

Monitoring and Evaluation of Plan Implementation

Managing and implementing the NFPCIP effectively will require a carefully developed and implemented framework and system for M&E. Although the M&E framework and indicators should link with the national HMIS, the HMIS includes only a limited number of indicators for FP. Hence, tools to collect monitoring data must be updated to include a comprehensive list of FP indicators. Because of the many activities and inputs that must be tracked to ensure timely and effective implementation of the NFPCIP, a management monitoring tool to track implementation of the strategic activities and achieving the objectives of the NFPCIP will be developed.

The M&E framework can be used routinely at several levels, including the government, the FP Working Group, development partners, and donors to track achievement of the implementation actions and activities, to identify problem areas in implementation or shortfalls in resources. Developing and applying an M&E framework has been facilitated by the inclusion in the NFPCIP of success indicators for each implementation action and the activities and steps expected to be carried out under each. Success indicators for the NFPCIP are expressed in terms of outputs and outcomes to be achieved by each activity. Ultimately, successful implementation of the NFPCIP must be measured in terms of its effect on contraceptive prevalence, but measuring the effect is beyond the capacity of the proposed M&E system and is instead provided by the DHS, which will occur next in 2009–2010 and 2014–2015.

Finally, the implementation actions and activities recommended in the NFPCIP are evidence-based. Over the five years of implementing the NFPCIP, however, new issues and questions will undoubtedly arise about the most cost-effective alternatives for implementation, or additional evidence will be required as a basis for scale-up of program components. These issues and questions can help to inform a research agenda to support continued innovation and ensure a sound, evidence-based program to reach the NFPCIP targets.